SAINT FRANCIS MEDICAL CENTER
530 NE GLEN OAK AVE
PEORIA IL 61603-3117
FACESHEET

KRAMER,MADELINE H
MRN: 05477474
DOB: 1/20/2013, Sex: F
Acct #: 24905718
Adm: 11/9/2013, D/C: 11/10/2013

Patient Demographics

Name	Patient ID	SSN	Sex	Birth Date
Kramer, Madeline H	05477474	xxx-xx-9999	Female	01/20/13 (9 mos)

Address	Phone	EMail	Employer
2830 4th St Apt 13 PERU IL 61354	815-876-7479 (H)	askagain@email.com	CHILD

Reg Status	PCP	Date Last Verified	Next Review Date
Verified	Krieger, Michelle A, MD815-433-1010	02/13/15	03/15/15

Marital Status	Religion	Language
Single	None	English

Emergency Contact 1
Julia Eickmeier (MOTHER)
20509 2300 North Ave
800-252-2873 (H)
815-876-7479 (M)

Patient Ethnicity & Race

Ethnic Group	Patient Race
Not Hispanic or Latino	White or Caucasian

Hospital Account

Name	Acct ID	Class	Status	Primary Coverage
Kramer, Madeline H	24905718	Outpatient with Observation Services	Closed	MEDICAID ILLINOIS - IL HEALTH CONNECT

Guarantor Account (for Hospital Account #24905718)

Name	Relation to Pt	Service Area	Active?	Acct Type
Eickmeier, Julia		OSF-S	Yes	Personal/Family

Address	Phone
2830 4TH ST TRLR 13 PERU, IL 61354-3171	815-876-7479(H)

Coverage Information (for Hospital Account #24905718)

F/O Payor/Plan	Precert #
MEDICAID ILLINOIS/IL HEALTH CONNECT	

Subscriber	Subscriber #
Kramer, Madeline	223162108

Address	Phone
PO Box 19105 SPRINGFIELD, IL 62794-9105	877-912-1999

Admission Information

Attending Provider	Admitting Provider	Admission Type	Admission Date/Time
	Vazquez-Melendez, Elsa V, MD	Emergency	11/09/13 2345

Discharge Date/Time	Hospital Service	Auth/Cert Status	Service Area
11/10/13 1928	Pediatrics	Incomplete	OSF HEALTHCARE SA

Unit	Room/Bed	Admission Status
SFMC GENERAL PEDIATRICS	626/626-01	Discharged (Confirmed)

Admission Information - Hospital Account/Patient Record

Arrival Date/Time:	11/09/2013 10:38 PM	Admit Date/Time:	11/09/2013 10:38 PM	IP Adm. Date/Time:	None
Admission Type:	Emergency	Point of Origin:	Non-health Care Facility Point Of Origin	Admit Category:	None
Means of Arrival:	Car	Primary Service:	Pediatrics	Secondary Service:	None
Transfer Source:	None	Service Area:	Osf Healthcare Sa	Unit:	Sfmc General Pediatrics

Admission Information - Hospital Account/Patient Record (continued)

Admit Provider:	Vazquez-Melendez, Elsa V, MD	Attending Provider:	Vazquez-Melendez, Elsa V, MD	Referring Provider:	None

Final Diagnoses (ICD-9-CM)

Principal	Code	Name	POA	CC	HAC	Affects DRG
[P]	V71.5	Observation following alleged rape or seduction				

Discharge Information - Hospital Account/Patient Record

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
11/10/2013 7:28 PM	Discharged To Home Or Selfcare	None	None	Sfmc General Pediatrics

Allergies as of 11/10/2013 — **Reviewed** On: **11/10/2013** By: **Viviano, Andrea K, RN**

No Known Allergies

Current Immunizations — Never Reviewed

No immunizations on file.

Patient History Informatation

Medical

as of 11/10/2013

Surgical

as of 11/10/2013

Family **None**

as of 11/10/2013

Family Status	Relation	Name	Status	Death Age	Comments	Source
as of 11/10/2013	Mother		Alive			Provider

Tobacco Use	Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
as of 11/10/2013	Never Smoker	Provider		0.0	0.0				Unknown	

Alcohol Use	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
as of 11/10/2013	Not Asked	Provider			

Drug Use	Drug Use	Source	Types	Frequency	Comments
as of 11/10/2013	Not Asked	Provider		0.00	

Sexual Activity	Sexually Active	Source	Birth Control	Partners	Comments
as of 11/10/2013	Not Asked	Provider			

Social ADL	ADL Question	Response	Comments	Source
as of 11/10/2013	**None**			

Social Doc **None**

as of 11/10/2013

Occupational as of 11/10/2013 **None**

Socioeconomic as of 11/10/2013

Marital Status	Spouse Name	Num of Children	Years Education	Source
Single				

Preferred Language	Ethnicity	Race
English	Not Hispanic or Latino	White or Caucasian

Birth **None**

Problem List Reviewed: **11/10/2013 2:09 AM by Couri, Maria E, MD**

	Noted	Noted By	Resolved	Resolved By
Suspected child sexual abuse	11/10/2013	Adams, Maria E, MD	No	

ED Arrival Information

Expected	Arrival	Acuity	Means of Arrival	Escorted By	Service	Admission Type
-	11/9/2013 22:38	Emergent	Car	Family Member	Pediatrics	Emergency

Arrival Complaint

-

ED Disposition

Admitted
Admitting Physician: VAZQUEZ-MELENDEZ, ELSA V [19007433]
Admitting Diagnosis: alleged abuse
Level of Care: General Acute
Patient Care Floor/Unit: general pediatrics
Patient Class: Outpatient with Observation Services [104]

Initial Provider Contact

Date/Time	Event	User	Comments
11/10/13 0009	Initial Provider Contact	MONTGOMERY, DANIEL L	

ED Notes

ED Provider Notes by Hauter, William E, MD at 11/9/2013 10:32 PM Version 3 of 3

Author: Hauter, William E, MD | Service: (none) | Author Type: Physician
Filed: 11/12/2013 10:32 AM | Note Time: 11/9/2013 10:32 PM | Status: Addendum
Editor: Hauter, William E, MD (Physician)
Related Notes: Original Note by Hauter, William E, MD (Physician) filed at 11/10/2013 11:10 PM

Chief Complaint
Patient presents with
- sexual assault

HPI
Madeline Kramer is a 9 m.o. female brought in by her mother for evaluation for suspected abuse. Mother states that child has not been alone with father of baby over 2 months. No current medical concerns per mother, she is requesting professional evaluation for suspected abuse.

No current facility-administered medications for this encounter.

No current outpatient prescriptions on file.

No Known Allergies

History reviewed. No pertinent past medical history.

No past surgical history on file.

History

Social History
- Marital Status: Single
  - Spouse Name: N/A
  - Number of Children: N/A
- Years of Education: N/A

Occupational History
- Not on file.

Social History Main Topics
- Smoking status: Never Smoker
- Smokeless tobacco: Not on file
- Alcohol Use: Not on file
- Drug Use: Not on file
- Sexually Active: Not on file

Other Topics | Concern
- Not on file

Social History Narrative
- No narrative on file

BP 91/43 | Pulse 138 | Temp 98 °F (36.7 °C) (Axillary) | Resp 26 | Ht 26.38" | Wt 18 lb 14.7 oz (8.58 kg) | BMI 19.11 kg/m2 | HC 46.5 cm (18.31") | SpO2 100%

Review of Systems
Constitutional: Negative for fever.
HENT: Negative for rhinorrhea.
Eyes: Negative for discharge.
Respiratory: Negative for cough.
Cardiovascular: Negative for cyanosis.
Gastrointestinal: Negative for vomiting and diarrhea.
Genitourinary: Negative for decreased urine volume.
Musculoskeletal: Negative for joint swelling.
Skin: Negative for rash.
Neurological: Negative for seizures.

Physical Exam
Constitutional: She appears well-developed. She has a strong cry. No distress.
HENT:
Head: Anterior fontanelle is flat.
Right Ear: Tympanic membrane normal.
Left Ear: Tympanic membrane normal.
Mouth/Throat: Mucous membranes are moist. Oropharynx is clear.
Eyes: Conjunctivae are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Normal rate, regular rhythm, S1 normal and S2 normal. Pulses are palpable. No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress.
Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. No tenderness.
Genitourinary: No labial rash. No labial fusion.
Musculoskeletal: She exhibits no edema, no deformity and no signs of injury.
Lymphadenopathy:
She has no cervical adenopathy.
Neurological: She is alert.
Skin: Skin is warm. Capillary refill takes less than 3 seconds. No rash noted.

Procedures

MDM

Coding

Clinical Impression

1. **Suspected child sexual abuse**

ED Course:
Pt seen initially and evaluated by SANE nurse.
Discussed case with Dr. Kendhari for PRC consult Recommends admission for further evaluation.
Pt looks well, no medical intervention needed.
Pt admitted to peds hospitalist service.

I have supervised and coordinated the care of this patient with the resident physician and ancillary staff. I have also reviewed the patient's laboratory, bedside testing and radiographic tests. I have reviewed and agree with the resident's History/Physical and Assessment/Plan unless noted as highlights, additions, deletions and/or addendums
MR: 05477474 CSN: 54758134
Admit: 11/09/2013 Disch: 11/10/2013
DocID: D2417145

D.11/10/2013 23:10:51
T.11/11/2013 10:53:08

The patient's parent was interviewed by the Resident Physician. The SANE nurse did evaluate the patient. I spoke with the Pediatric Resource Attending, and they would like the patient to be admitted to the hospital so they can evaluate the social situation and the most appropriate place for this patient to be discharged to after a period of observation.

Job #5707116
ljc

Version Date: 11/11/2013 13:36:23
ljw

ELSA V VAZQUEZ-MELENDEZ, Admitting Physician
TEAM, PEDS PEDIATRIC TEACHING ON CA, Consulting Physician 1
MICHELLE A KRIEGER, Primary Care Physician

ED Provider Notes by Hauter, William E, MD at 11/9/2013 10:32 PM (continued) Version 3 of 3

ED Provider Notes by Hauter, William E, MD at 11/9/2013 10:32 PM Version 2 of 3

Author: Hauter, William E, MD | Service: (none) | Author Type: Physician
Filed: 11/10/2013 11:10 PM | Note Time: 11/9/2013 10:32 PM | Status: Addendum
Editor: Hauter, William E, MD (Physician)
Related Notes: Addendum by Hauter, William E, MD (Physician) filed at 11/12/2013 10:32 AM
Original Note by Montgomery, Daniel L, MD (Resident) filed at 11/10/2013 11:01 PM

Chief Complaint
Patient presents with
- sexual assault

HPI
Madeline Kramer is a 9 m.o. female brought in by her mother for evaluation for suspected abuse. Mother states that child has not been alone with father of baby over 2 months. No current medical concerns per mother, she is requesting professional evaluation for suspected abuse.

No current facility-administered medications for this encounter.

No current outpatient prescriptions on file.

No Known Allergies

History reviewed. No pertinent past medical history.

No past surgical history on file.

History

Social History
- Marital Status: Single
  - Spouse Name: N/A
  - Number of Children: N/A
- Years of Education: N/A

Occupational History
- Not on file.

Social History Main Topics
- Smoking status: Never Smoker
- Smokeless tobacco: Not on file
- Alcohol Use: Not on file
- Drug Use: Not on file

- Sexually Active: Not on file

Other Topics	Concern
• Not on file	

Social History Narrative
- No narrative on file

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Skin: Negative for rash.
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Right Ear: Tympanic membrane normal.
Left Ear: Tympanic membrane normal.
Mouth/Throat: Mucous membranes are moist. Oropharynx is clear.
Eyes: Conjunctivae are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Normal rate, regular rhythm, S1 normal and S2 normal. Pulses are palpable.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress.
Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. No tenderness.
Genitourinary: No labial rash. No labial fusion.
Musculoskeletal: She exhibits no edema, no deformity and no signs of injury.
Lymphadenopathy:
She has no cervical adenopathy.
Neurological: She is alert.
Skin: Skin is warm. Capillary refill takes less than 3 seconds. No rash noted.

Procedures

ED Provider Notes by Hauter, William E, MD at 11/9/2013 10:32 PM (continued) Version 2 of 3

MDM

Coding

Clinical Impression
1. **Suspected child sexual abuse**

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Pt seen initially and evaluated by SANE nurse.
Discussed case with Dr. Kendhari for PRC consult Recommends admission for further evaluation.
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Pt admitted to peds hospitalist service.

I have supervised and coordinated the care of this patient with the resident physician and ancillary staff. I have also reviewed the patient's laboratory, bedside testing and radiographic tests. I have reviewed and agree with the resident's History/Physical and Assessment/Plan unless noted as highlights, additions, deletions and/or addendums
Dictation on: 11/10/2013 11:10 PM by: HAUTER, WILLIAM E [WEHAUTER]

ED Provider Notes by Montgomery, Daniel L, MD at 11/9/2013 10:32 PM Version 1 of 3

Author: Montgomery, Daniel L, MD | Service: (none) | Author Type: Resident
Filed: 11/10/2013 11:01 PM | Note Time: 11/9/2013 10:32 PM | Status: Signed
Editor: Montgomery, Daniel L, MD (Resident)
Related Notes: Addendum by Hauter, William E, MD (Physician) filed at 11/10/2013 11:10 PM
Cosigner: Hauter, William E, MD at 11/10/2013 11:10 PM

Chief Complaint
Patient presents with
- sexual assault

HPI
Madeline Kramer is a 9 m.o. female brought in by her mother for evaluation for suspected abuse. Mother states that child has not been alone with father of baby over 2 months. No current medical concerns per mother, she is requesting professional evaluation for suspected abuse.

No current facility-administered medications for this encounter.

No current outpatient prescriptions on file.

No Known Allergies

History reviewed. No pertinent past medical history.

No past surgical history on file.

History

Social History

- Marital Status: Single
  - Spouse Name: N/A
  - Number of Children: N/A
- Years of Education: N/A

Occupational History

- Not on file.

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Not on file
- Alcohol Use: Not on file
- Drug Use: Not on file
- Sexually Active: Not on file

Other Topics Concern

- Not on file

Social History Narrative

- No narrative on file

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Genitourinary: Negative for decreased urine volume.
Musculoskeletal: Negative for joint swelling.
Skin: Negative for rash.
Neurological: Negative for seizures.

Physical Exam
Constitutional: She appears well-developed. She has a strong cry. No distress.
HENT:
Head: Anterior fontanelle is flat.

ED Notes (continued)

ED Provider Notes by Montgomery, Daniel L, MD at 11/9/2013 10:32 PM (continued) Version 1 of 3

Right Ear: Tympanic membrane normal.
Left Ear: Tympanic membrane normal.
Mouth/Throat: Mucous membranes are moist. Oropharynx is clear.
Eyes: Conjunctivae are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Normal rate, regular rhythm, S1 normal and S2 normal. Pulses are palpable.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress.
Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. No tenderness.
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Musculoskeletal: She exhibits no edema, no deformity and no signs of injury.
Lymphadenopathy:
She has no cervical adenopathy.
Neurological: She is alert.
Skin: Skin is warm. Capillary refill takes less than 3 seconds. No rash noted.

Procedures

MDM

Coding

Clinical Impression
1. **Suspected child sexual abuse**

ED Course:
Pt seen initially and evaluated by SANE nurse.
Discussed case with Dr. Kendhari for PRC consult Recommends admission for further evaluation.
Pt looks well, no medical intervention needed.
Pt admitted to peds hospitalist service.

ED Notes by Leyden, Melinda M, RN at 11/10/2013 1:57 AM Version 1 of 1

Author: Leyden, Melinda M, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 1:58 AM | Note Time: 11/10/2013 1:57 AM | Status: Signed
Editor: Leyden, Melinda M, RN (Registered Nurse)

Report given to Andi, gen peds RN.

ED Notes by Leyden, Melinda M, RN at 11/10/2013 12:12 AM Version 1 of 1

Author: Leyden, Melinda M, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 1:57 AM | Note Time: 11/10/2013 12:12 AM | Status: Signed
Editor: Leyden, Melinda M, RN (Registered Nurse)

ED Notes (continued)

ED Notes by Leyden, Melinda M, RN at 11/10/2013 12:12 AM (continued) Version 1 of 1

9 month old female to ED with mother, Julia, who is concerned that pt may have been sexually assaulted possibly by pt's father. Julia states pt was last with father unsupervised around Labor Day of this year but he has had some supervised visitations with pt since then. During Labor Day visit, Julia states father "tried to kidnap her basically, and I had to get the police involved." Julia took pt to her pediatrician at the end of August for redness to vaginal area that was worse after pt stayed with father for a few days. Pt was diagnosed with a diaper rash at this time. Julia believes redness appeared as if pt was "fondled down there" and states "as a mom I know it wasn't diaper rash because it looked different than diaper rash she's had before." Julia reports there were other times that pt would come home after visitation with father with "white gunky stuff down there" or "her little vagina hole looked bigger and was red" and reports approx 3 months ago pt "started squeezing at her diaper and when she would catch her doing it she would tell her 'No!'" Julia states "I did research and that's one of the signs of sexual abuse. She's just a little baby, she should not be masturbating herself." Julia brings camera with pictures of these symptoms she described. This RN did not visualize the pictures. Julia reports "having a dream and seeing it happen" and "a spirit came and told her that her child was being abuse, couldn't she see it?" This when she realized that "it really was happening." Julia states that pt's father "is Satanic. He is very secretive about it but I'm pretty sure he is." Julia reports that some Satanists use "SRA, Satanic Ritual Abuse, and do this to children." Julie voices concern about pt's fathers mother, who "constatnly tries to sneak and see my baby." Julia states last time pt saw father was this evening, supervised by Julia, and they went to coffee together.

Upon physical exam, pt acting age appropriate, smiling and giggling. No bruising, redness, swelling, or other injury noted to vaginal area or other parts of body. Mother states pt has been eating well and having appropriate amount of wet diapers. Breathing even and unlabored. Skin P/W/D. VSS. PEWS score 0.

ED Notes by Leyden, Melinda M, RN at 11/10/2013 1:32 AM Version 1 of 1

Author: Leyden, Melinda M, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 1:33 AM | Note Time: 11/10/2013 1:32 AM | Status: Signed
Editor: Leyden, Melinda M, RN (Registered Nurse)

Officer McMillan with PPD has spoken with pt. Police officer states reports were made in another county and no report is necessary at this time. Officer did confirm that mother has custody of child at this time.

ED Notes by Tiraboschi, Anthony J, RN at 11/10/2013 12:51 AM Version 1 of 1

Author: Tiraboschi, Anthony J, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 12:51 AM | Note Time: 11/10/2013 12:51 AM | Status: Signed
Editor: Tiraboschi, Anthony J, RN (Registered Nurse)

PPD at bedside.

ED Notes by Leyden, Melinda M, RN at 11/10/2013 12:42 AM Version 1 of 1

ED Notes (continued)

ED Notes by Leyden, Melinda M, RN at 11/10/2013 12:42 AM (continued) Version 1 of 1

Author: Leyden, Melinda M, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 12:43 AM | Note Time: 11/10/2013 12:42 AM | Status: Signed
Editor: Leyden, Melinda M, RN (Registered Nurse)

Peoria Police Dept called and notified that pt is here for sexual assault. Will be sending officer to ED to speak with pt's mother and see if report needs to be made.

ED Notes by Leyden, Melinda M, RN at 11/10/2013 12:36 AM Version 1 of 1

Author: Leyden, Melinda M, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 12:38 AM | Note Time: 11/10/2013 12:36 AM | Status: Signed
Editor: Leyden, Melinda M, RN (Registered Nurse)

Dr Kindari, on call with Peds Resource Center, informed of allegations of sexual assault against patient. Per Dr Kindari, pt is to be admitted for observation and she will see pt in the morning. Dr Kindari spoke with Dr Hauter regarding POC.

ED Notes by Leyden, Melinda M, RN at 11/10/2013 12:34 AM Version 1 of 1

Author: Leyden, Melinda M, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 12:36 AM | Note Time: 11/10/2013 12:34 AM | Status: Signed
Editor: Leyden, Melinda M, RN (Registered Nurse)

DCFS will call this RN back when representative is available.

ED Notes by Jetton, Leslie R, RN at 11/9/2013 11:31 PM Version 1 of 1

Author: Jetton, Leslie R, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/9/2013 11:32 PM | Note Time: 11/9/2013 11:31 PM | Status: Signed
Editor: Jetton, Leslie R, RN (Registered Nurse)

Room pt to be assigned to is being cleaned. Pt's mother updated.

ED Notes by Jetton, Leslie R, RN at 11/9/2013 10:41 PM Version 1 of 1

Author: Jetton, Leslie R, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/9/2013 10:43 PM | Note Time: 11/9/2013 10:41 PM | Status: Signed
Editor: Jetton, Leslie R, RN (Registered Nurse)

Per Derek, RN, the previous charge nurse on shift, the call center called ahead of pt arrival. Call center reports that mother called from Ohio, IL with allegations that the pt's father may be sexually abusing the pt. The call center advised the pt be seen. Pt will be roomed as soon as the SANE nurse on staff tonight has an available room.

Hospital Encounter Notes

Discharge Summaries

Discharge Summaries by Vazquez-Melendez, Elsa V, MD at 12/10/2013 3:03 PM

Author: Vazquez-Melendez, Elsa V, MD | Service: (none) | Author Type: Physician
Filed: 12/12/2013 1:54 PM | Note Time: 12/10/2013 3:03 PM | Status: Signed
Editor: Vazquez-Melendez, Elsa V, MD (Physician)
Related Notes: Related Note by Logan, Tori, DO (Resident) filed at 12/10/2013 3:09 PM

I have seen and evaluated the patient. I discussed the patient's management with the house staff team. I agree with the findings and plan as outlined in the resident's note.

Principal Problem:
*Suspected child sexual abuse

Dr Krieger, Michelle A was notified of the patient's discharge
Less than 30 minutes spent in coordinating care

By: *ELSA V VAZQUEZ-MELENDEZ, MD, 12/12/2013, 1:54 PM*

Primary Care Physician: Krieger, Michelle A

Discharge Summaries by Logan, Tori, DO at 12/10/2013 3:03 PM

Author: Logan, Tori, DO | Service: (none) | Author Type: Resident
Filed: 12/10/2013 3:09 PM | Note Time: 12/10/2013 3:03 PM | Status: Signed
Editor: Logan, Tori, DO (Resident)
Related Notes: Cosigned by Vazquez-Melendez, Elsa V, MD (Physician) filed at 12/12/2013 1:54 PM

CHS DISCHARGE SUMMARY

Name: Madeline Kramer **MRN:** 05477474	**Age:** 10 m.o. **DOB:** 1/20/2013
Admission Date/Time: 11/9/2013 11:45 PM	**Discharge Date:** 11/10/13
Primary Care Physician: Krieger, Michelle A	**Attending Physician:** No att. providers found **Discharging Physician:** Tori Logan, DO

INSTRUCTIONS FOR PHYSICIANS ON FOLLOW UP AFTER DISCHARGE:

Follow-up with PCP: Krieger, Michelle A in 2 days

Follow up Diagnostic Recommendations: none
Pending Labs/Path/Imaging: none

Discharge Instructions:

Discharged Condition: not changed
Disposition: Home
Diet: Regular Diet
Activity: Activity As Tolerated
Resuscitation Status at Discharge: Full code
Discharge Diagnoses: parental concern for child sexual abuse

Discharge Diagnosis:

Admission Diagnosis: Suspected child sexual abuse
Discharge Diagnoses:

Active Hospital Problems

Diagnosis	Date Noted
• Suspected child sexual abuse	11/10/2013

Resolved Hospital Problems

Diagnosis	Date Noted	Date Resolved
No resolved problems to display.		

HOSPITAL COURSE:

Madeline was seen in the ED for suspected child sexual abuse by mother. Mother noticed redness in her diaper area after returning from an unsupervised visit with the child's father September 2nd. There were no new findings to relate acutely. Madeline was admitted for further evaluation by the Pediatric Resource Center. She remained medically stable for her stay. She was discharged home after 1 day after being seen by Pediatric Resource Center as well as DCFS. Mother agreed to plan of care and comfortable with discharge and follow-up.

Consults: Pediatric Resource Center
Consultant recommendations: Discharge home with follow-up with PRC as well as DCFS.

Lab / Imaging Review:

Summary of significant lab and imaging findings:
Lab: none
Radiology: none

DISCHARGE MEDICATION LIST:

There are no discharge medications for this patient.

PCP Notification: Dr. Krieger, Michelle A was notified of the patient's discharge on 12/10/2013 by CHS Service.

Thank you for allowing the Children's Hospitalist Service to participate in the care of your patient. Please feel free to contact us for any additional questions.

Signed: *Tori Logan, DO, 12/10/2013, 3:04 PM*

History & Physicals

H&P by Vazquez-Melendez, Elsa V, MD at 11/10/2013 1:59 AM

Author: Vazquez-Melendez, Elsa V, MD | Service: (none) | Author Type: Physician
Filed: 11/10/2013 1:19 PM | Note Time: 11/10/2013 1:59 AM | Status: Signed
Editor: Vazquez-Melendez, Elsa V, MD (Physician)
Related Notes: Related Note by Logan, Tori, DO (Resident) filed at 11/10/2013 3:04 AM

Pediatric Hospitalist Comments:

Madeline Kramer is a 9 m.o. female Hospital day LOS: 1 day
Active Problems:
Suspected child sexual abuse

I have seen and evaluated the patient with the residents during rounds. I discussed the patient's management with the house staff team. I agree with the findings and plan as outlined in the resident's note

Discharge Planning:ongoing
Attending Physician: *ELSA V VAZQUEZ-MELENDEZ, MD; 11/10/2013, 1:18 PM*

H&P by Logan, Tori, DO at 11/10/2013 1:59 AM

Author: Logan, Tori, DO | Service: (none) | Author Type: Resident
Filed: 11/10/2013 3:04 AM | Note Time: 11/10/2013 1:59 AM | Status: Signed
Editor: Logan, Tori, DO (Resident)
Related Notes: Cosigned by Vazquez-Melendez, Elsa V, MD (Physician) filed at 11/10/2013 1:19 PM

Pediatric Admission History and Physical Examination

Admit Date: 11/9/2013
Attending: Elsa Vazquez-Melendez V, MD
PCP: Krieger, Michelle A

Assessment

Madeline Kramer is a 9 m.o. female, no significant PMH, presents to OSF ED with mother for suspected sexual abuse.

Plan

Will admit to general pediatrics for overnight observation with Pediatric Resource Consult.
No continuous monitoring needed as child is stable.
Q4H VS

FEN: formula feeds ad lib, jar baby food ad lib

CC: suspected sexual abuse

History of Present Illness

Madeline is a 9 m.o. female, no significant PMH, presents for suspected sexual abuse. She is accompanied by mother.

Mother brings Madeline to OSF ED tonight because she has concerns that Madeline has been sexually abuse while visiting her father's house. Her concerns started at age 4-6 months when Madeline would come home from her father's house looking "dirty" as if she had not been bathed. It was during this period of time she also began "squeeze her diaper area as if she was self-stimulating" after a visit with her father. In August they had a court date to get Dad's name on the birth certificate, it was after this meeting that mother states "he basically kidnapped her and said there was nothing I could do because his name was on the birth certificate now". His last unsupervised visit was September 2nd of 2013, it was after this visit that mom states Madeline came back and she noticed that her vaginal area appeared red and looked as if the opening was larger than previously. Mother denies ever noticing any bleeding, bruising or vaginal discharge. She was evaluated by her primary care physician who diagnosed diaper dermatitis. Patient is eating and drinking normally with no other complaints.

When mother asked why she came to ED tonight for evaluation after being evaluated by PCP and outlying hospital for same complaint she states, "I have an upcoming court date to decide if father will get unsupervised visitation rights and was told there were specialists here who could tell if she has been abused." She has given father supervised visitations with Madeline 2-3 times per week since September 2nd even though "he has threatened to murder me". Mother states "It's like a game I have to play with the legal system" allowing the father to see the baby. She states she is hoping for sole custody after the next court date. Mother states she noticed none of the erythema or abnormal size of the opening today as it occurred two months ago, and that "everything looks normal down there now".

Review of Systems

A 14 point Review of Systems was performed and was negative except as noted in the HPI.

Past Medical, Family, Social History

Birth Hx: SVD with no complications at 40 weeks gestation
PMHx: None per mother
PSHx: No surgeries
FMHx: Mother states that mental illness runs in the father's family including schizophrenia in patient's uncle and suspected in father. Maternal side of family has hypertension.
Social Hx: Extensive court cases regarding child
Living situation: With family, mother and maternal grandfather
Has visitation with father who lives with paternal grandmother and paternal uncle.
School or daycare: stays home with mother during the day
Siblings (number and defining information): 0
Do parents smoke (inside/outside): no
Does the patient smoke/drink/do drugs (if over 12 years old): n/a
Allergies: No Known Allergies
Immunizations:
There is no immunization history on file for this patient.

Medications:
No prescriptions prior to admission

Developmental History: milestones have been achieved in a normal sequence and time
Diet/Nutrition: Enfamil Gentlease, also eats organic baby foods

Physical Examination:

Pulse 118 | Temp 97.7 °F (36.5 °C) (Axillary) | Resp 24 | Wt 19 lb (8.618 kg) | SpO2 99%
Normalized BMI data available only for age 2 to 20 years.
56.97%ile based on WHO weight-for-age data.
No height on file.
No unique date with height and weight on file.

GENERAL: well appearing female, in no acute distress
HEENT: Head: Atraumatic, normocephalic
Eyes: pupils equal and reactive, extraocular eye movements intact
Ear: Normal external auditory canal and tympanic membrane bilaterally
NT: mucous membranes moist, pharynx normal without lesions
NECK supple, no significant adenopathy
CV regular rate and rhythm, S1, S2 normal, no murmur, click, rub or gallop
PULM clear to auscultation, no wheezes or rales, unlabored breathing
ABD Normal appearance, soft, non-tender, without organ enlargement or masses.
GU: normal female, no erythema, ecchymosis or discharge
INTEG: Skin color, texture, turgor normal. No rashes, lesions or ecchymosis.
M/S: no joint tenderness, deformity or swelling, grossly normal
NEURO: alert and oriented, moving all four extremities equally, interacts appropriately with mother and physician, laughs when being tickled

Results Review:

Medication Reconciliation performed in the EMR by Tori Logan, DO: Yes.
Laboratory data reviewed in EMR: labs reviewed and significant for the following: none
Imaging reviewed in EMR: No: none performed. Significant results: n/a
Microbiology pending in Hospital laboratory: none

Tori Logan, DO
11/10/2013, 1:59 AM

Consult Notes

Consults by Kendhari, Harleena K, MD at 11/10/2013 12:53 PM

Author: Kendhari, Harleena K, MD | Service: (none) | Author Type: Physician
Filed: 11/18/2013 10:24 AM | Note Time: 11/10/2013 12:53 PM | Status: Addendum
Editor: Kendhari, Harleena K, MD (Physician)
Related Notes: Original Note by Kendhari, Harleena K, MD (Physician) filed at 11/11/2013 1:20 PM
Consult Orders:
1. IP Consult to Pediatric Resource Center [131064869] ordered by Logan, Tori, DO at 11/10/13 0211

PRC CONSULT

Subjective: 'I am worried about my daughter's safety'
Reason for Consultation: Mom is worried that 'Madeline has physical symptoms of sexual abuse'

Source of history: Madeline's Mother - Julia
HPI: Madeline's mother brought Madeline into the ED because she knew that we have special doctor's here (at OSF) and that she has a court case coming up and that she is worried about Madeline's safety. She has seen a doctor before in the past who was not specialized and she is not sure if that doctor can tell that difference between a diaper rash and someone hurting her.

Madeline's mother showed me the photographs of Madeline that she had taken when she had returned home from a visit with her Father - at that time she was worried that someone had molested her daughter because ' her opening down there was bigger than normal'. The photograph was a blurry cell phone photograph that showed the labia with a white substance around the labia - unable to identify - as photograph was very blurry.

Madeline's mother moved into a women's shelter when Madeline was two months old because she and Madeline's father "did not work out". Madeline's father (Kevin Kramer) moved in with his family and Madeline's mother moved out of the shelter after one month of residing here and moved into Madeline's biological grandfather's home. Madeline's mother was worried that after Madeline would go to her father's family's home she would come back with her vaginal area unclean and 'gunky' - this was when Madeline was about three months old.
During this time, Madeline's mother did move back in with Madeline father to 'try to work it out' but it did not work out and she was asked to leave the family property. This is when she was 5 months old. During this time, Madeline's father's family hired a babysitter to mind Madeline (a women who Madeline's mother did not know). When Madeline was 5 months old, Madeline's mother noticed a change in her behaviour and it was during this time that Madeline started 'diaper squeezing'. Madeline's mother describes diaper squeezing and putting pressure on the front of her diaper by crossing her legs and pushing towards the front area, 'almost as though she is stimulating herself. LIke masturbating.' This was during the first week that she was at the baby sitter's house.

Mom noticed that at the end of August (27th or 28th), Mom took Madeline took mom to the Dr's

office as she was concerned that Madeline's vaginal opening was 'more open' and that the skin around the opening of vagina was 'red, almost infected looking' and that "I know what a diaper rash looks like and that was not a diaper rash". This was after the court date,when Madeline's father's family took her after court and stated that they would bring her back Monday (the visit with them was Thursday from Monday, late late at night). She noticed the redness immediately upon changing her diaper when she had her baby returned.

Mom expresses concern that she is with them for a few days only and she has 'these' symptoms. Mom also notes that Madeline's father has threatened to 'murder her' and threatened to 'wipe her off the face of the earth'. She is worried that Madeline's father's is a song writer and some of his lyrics are graphic and talk about the 'blood of the innocents'. She also expressed concerns that Madeline's father has brought drugs into her home. But that she "has a sixth sense about these things" and she found them. She also describes a vivid dream where a "spirit told her to trust her instrincts" and then the dream continued with someone sexually molesting Madeline during a diaper change and " that's when I knew something was going on over there" (at Madeline father's home)

Mom states "she is doing the best she can with all the millions things she does now". ;" I used to be able to focus more on Madeline, but I hope I can pass some things on to other people the things I have learned"

Individuals present during medical history: Madeline, Madeline's Mother Julia and myself, Dr Kendhari

Past Medical History: Never been hospitalized
Vaginal delivery, at term 40 weeks gestation, 8lbs 20 inches
Discharged with mother after one day

Immunizations: Madeline is unimmunized - Mother does not believe in immunizations at this point - may consider Tetanus in the future

Developmental History: Sits on her own, pulling to stand, cruises along furniture. Says words "mama, dada, baba, up'

Diet History: Formula fed - mom is unsure how many ounces she drinks. She states 'with all this court stress, I am no longer keeping a log. "I go through a can of formula in under a week'. She will eat soft foods - apple sauce, organic baby foods. Mom will allow her to gnaw on apple slices and carrots - but she cannot eat them.

Past Surgical History: No surgeries

Family History: Maternal side: polycystic kidney disease. Maternal grandfather has high blood pressure. NO diabetes, no seizures, no bleeding disorders or nose bleeds or heavy periods. No easily broken bones

On Madeline's father's side, mental illness is present including paternal uncle who is schizophrenic. Madeline's mother suspects that Madeline's paternal grandfather is an alcoholic. Madeline's mother is not aware of any other medical problems on Madeline's father's side

Social History: Mom has custody of Madeline and lives Madeline lives with her. Madeline sees her father 2-4 times a week, in Madeline's mothers home (usually) or at the mall for a joint visit. Madeline doesn't see her father's family as much

Allergies: No allergies

Review of Systems: No cough, no runny nose, no vomitting, no diarrhea, no rashes, no fever, has been eating and drinking normally. All other sytems reviewed and negative unless mentioned in the HPI

Medications:

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• lidocaine (LMX) 4 % cream CREA		Topical	PRN	Logan, Tori, DO		

Objective:

VITALS: Patient Vitals for the past 12 hrs:

	BP	Temp	Temp src	Pulse	Resp	SpO2	Height	Weight
11/10/13 1153	-	97.6 °F (36.4 °C)	Axillary	116	24	-	-	-
11/10/13 0839	91/43 mmHg	97.2 °F (36.2 °C)	Axillary	127	24	98 %	-	-
11/10/13 0530	-	-	Axillary	110	24	98 %	-	-
11/10/13 0210	101/64 mmHg	97.8 °F (36.6 °C)	Axillary	178	27	100 %	26.38"	18 lb 14.7 oz (8.58 kg)

Weight:

Wt Readings from Last 1 Encounters:

11/10/13 18 lb 14.7 oz (8.58 kg) (55.57%*)

* Growth percentiles are based on WHO data.

Head Circumference:

HC Readings from Last 1 Encounters:

11/10/13 46.5 cm (18.31") (95.62%*)

* Growth percentiles are based on WHO data.

Height:

Ht Readings from Last 1 Encounters:

11/10/13 26.38" (6.28%*)

* Growth percentiles are based on WHO data.

EXAM:

Physical Examination:
Madeline is playful, non distressed, playing on the floor of the hospital room eating graham crackers
NC/AT, EOMI, PERRL, MMM, nares patent, graham cracker crumbs on face
TM pearly grey, cerumen noted in L canal
CTA-B, no W/R/R
RRR, S1=S2, no murmur noted, femoral pulses equal and symmetric
Belly soft, NTTP, no masses appreciated, positive bowel sounds
Moves all extremities spontaneously, strength equal and symmetric in upper and lower extremities
Neuro exam: Smiles, says mama during exam, pulling to stand against wall and chair. Reaches with both hands across midline, good grasp
GU exam: Labia majora with mild erythema, and no excoriation. Annular redundant hymen appreciated, with maternal estrogen effects still present. Anus patent without erythema

Data Review: *I have reviewed all epic medical records including Emergency Room Medical records from OSF St Francis Medical Center and Krieger, Michelle A primary care office. Significant are the notes from nursing staff on 11/8/2013 and 11/9/2013 describing Madeline's mother's concerns about Madeline and Madeline's father's family.

Outside reports reviewed: none

Assessment

Madeline is a nine month old otherwise healthy female who presents with her Mother who has concerns that her daughter has been abused - initial concern in August when Madeline's mother reports that Madeline returned from visiting Madeline's father's home and returned with her vaginal opening appearing larger. Madeline's mother was also concerned about erythema in her vagina

Consult Notes (continued)

Consults by Kendhari, Harleena K, MD at 11/10/2013 12:53 PM (continued)

that was not a diaper rash. Madeline's mother also feels concerned for Madeline's safety.
Madeline's mother was concerned about Madeline masturbating. Masturbation is not a concern at this age, as developmentally, body curiosity at this age is normal.
Madeline's mother was also concerned about sexual molestation, reporting that the hymenal opening looking larger than it should. The size of the hymenal opening is not a factor in determining if sexual abuse took place.
Madeline had a normal anogenital exam, with the exception of some mild redness to the labia which is a non-specific finding.
A normal exam does not exclude the possibility of sexual abuse as exam following non-acute incidents are sexual are normal greater than 95% of the time. When evaluating concerns for abuse, the history is always the most important element.

Recommendations:

1. Ensure Madeline's safety
2. Will refer to PRC for further work up including colposcopic exam if deemed necessary
3. Will recommend to medical team discharge home today
4. Follow up with DCFS investigation

I have spent 60 minutes in this visit with the patient/family. Greater than 50% of this time was spent on counseling coordination of care.

By: *HARLEENA K KENDHARI, MD, 11/10/2013, 12:53 PM*

Operative Notes

No notes of this type exist for this encounter.

Procedure Notes

No notes of this type exist for this encounter.

Progress Notes

No notes of this type exist for this encounter.

Additional Notes

Interdisciplinary by Lindberg, Danielle N, RN at 11/10/2013 7:09 PM

Author: Lindberg, Danielle N, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 7:13 PM | Note Time: 11/10/2013 7:09 PM | Status: Signed
Editor: Lindberg, Danielle N, RN (Registered Nurse)

Patient discharged to home. No discharge medications for pharmacy to review. Discharge instructions reviewed with mother. Mother to make appointment with primary care physician as needed. Mother denies any further questions or needs at this time.

Mother to return home to maternal grandfathers home tonight.

Interdisciplinary by Lindberg, Danielle N, RN at 11/10/2013 5:38 PM

Author: Lindberg, Danielle N, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 6:03 PM | Note Time: 11/10/2013 5:38 PM | Status: Signed
Editor: Lindberg, Danielle N, RN (Registered Nurse)

DCFS caseworker present. At patient bedside to to talk with mother.

Interdisciplinary by Lindberg, Danielle N, RN at 11/10/2013 3:20 PM

Author: Lindberg, Danielle N, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 3:34 PM | Note Time: 11/10/2013 3:20 PM | Status: Signed
Editor: Lindberg, Danielle N, RN (Registered Nurse)

Mother called RN to bedside to look at patient. Mom stated that patient "was squeezing her diaper area again". Mother stated "this is what she was doing when I got her back from her dad's". Upon assessment Madeline was lying in crib, holding blanket. Legs were crossed. Madeline appeared content and showed no signs of pain or distress.

ROC notified, ROC to come to bedside to assess patient.

Interdisciplinary by Lindberg, Danielle N, RN at 11/10/2013 3:28 PM

Author: Lindberg, Danielle N, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 3:31 PM | Note Time: 11/10/2013 3:28 PM | Status: Signed
Editor: Lindberg, Danielle N, RN (Registered Nurse)

DCFS representative Megan Sturdavant called RN back stating that report was not made for patient admission to hospital. DCFS representative stated that caseworker Heidi Creasy will be up this afternoon to see patient.

Interdisciplinary by Lindberg, Danielle N, RN at 11/10/2013 2:34 PM

Author: Lindberg, Danielle N, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 2:35 PM | Note Time: 11/10/2013 2:34 PM | Status: Signed
Editor: Lindberg, Danielle N, RN (Registered Nurse)

Nursing: RN spoke with DCFS representative regarding need for clearance for discharge. DCFS representative will call RN back once information is available.

Additional Notes (continued)

Interdisciplinary by Lindberg, Danielle N, RN at 11/10/2013 2:34 PM (continued)

Interdisciplinary by Haedicke, Rita A, RN at 11/10/2013 10:20 AM

Author: Haedicke, Rita A, RN | Service: (none) | Author Type: Patient Care Facilitator
Filed: 11/10/2013 10:40 AM | Note Time: 11/10/2013 10:20 AM | Status: Signed
Editor: Haedicke, Rita A, RN (Patient Care Facilitator)

Interdisciplinary Team Note

Reason for Admission & Relevant Hospital Problems: Maternal concern for sexual abuse
Length of Stay: LOS: 1 day

Goals/Barriers & Summary of Plan of Care: 9 mos old; goal to determine safe home environment for infant; Current custody battle in progress; DCFS/Social services/PRC consulted

DISCHARGE PLAN: Anticipate hospitalization until safe home placement has been determined

Anticipated Discharge *Durable Medical Equipment needs:: (n/a)*

Patient/family not currently in room; will remain available as patient needs arise
Inpatient: Consults/Referrals: Medical Social Worker;Child Protective Services

Discharge Evaluation:

PCP: Krieger, Michelle A

Living Arrangements: Parent
Primary Caregiver: family
Type of Residence: Private residence
Care Facility Name: n/a
Support Systems: Parent
Home Care Services: No
Type of Home Care Services: None
Prior to arrival Assistance Needed: n/a

Anticipated Changes Related To Illness: inability to care for self
Services Anticipated At Discharge: none
Anticipated Discharge Disposition: home with assist

Payor Source: Medicaid Illinois
Prescription Drug Coverage: Yes

Does the patient/caregiver have any financial concerns regarding discharge needs?: None
Mode of transportation at discharge:: Family car

Current DME being used by patient: none

Additional Notes (continued)

Interdisciplinary by Haedicke, Rita A, RN at 11/10/2013 10:20 AM (continued)

The list of facilities/home health/DME options was provided to the patient/caregiver?: No
Providers in which OSF have a financial interest identified to patient/family

READMISSION RISK FACTORS:	
Problem Medications	*Education needs of PTA/current meds: No* *Financial needs of PTA/current meds: No* *Patient Safety needs of PTA/current meds: No*
Pharmacy Medication Adherence	*How often do you miss taking your medication?: Never* *How often do you miss taking your medication?: Never*
Psychological	*Patient not screened due to:: Under age 18*
Principal Diagnosis	*Is principal diagnosis a high risk diagnosis?: No*
Patient Lacks Support	Does patient lack support?: No
Poor Health Literacy	*Is patient able to state reason for admission?: Yes*
Prior Hospitalization	*Non-elective, ED, INPT or OBS in last 6 months at any facility? : No*
Palliative Care	*Does this patient have a chronic illness that might get worse over time?: No* *Does the patient have chronic uncontrolled pain?: No*

Rita A Haedicke, RN
Care Transition Coordinator
Phone : 309-634-1244

Interdisciplinary by Lindberg, Danielle N, RN at 11/10/2013 10:15 AM

Author: Lindberg, Danielle N, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 10:21 AM | Note Time: 11/10/2013 10:15 AM | Status: Signed
Editor: Lindberg, Danielle N, RN (Registered Nurse)

Mother called RN into patient room to show RN what "patient's vagina looks like now, that the vagina hole looks pink and normal." Mother stated in August "patient's vaginal hole was bigger, and

Additional Notes (continued)

Interdisciplinary by Lindberg, Danielle N, RN at 11/10/2013 10:15 AM (continued)

it looked like she had been fondled with".
Explained to mother that physician from the Pediatric Resource Center will be by to assess patient and go over any concerns with mother. Mother verbalized understanding and was appreciate of care her daughter is receiving here.

Upon physical assessment patient appears comfortable. No redness, swelling, or other injury noted to vaginal area. No apparent injury to other parts of body. Will continue to monitor.

Lab Orders and Results

Lab Orders and Results

No orders and results found

Rad Orders and Results

Rad Orders and Results

No orders and results found

ECG/EMG Orders and Results

ECG/EMG Orders and Results

No orders and results found

Other Orders

Medication Orders (11/10/13 - 11/10/13)

lidocaine (LMX) 4 % cream CREA [131064855]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0211**
Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211
Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
PRN reasons:
Procedure Other
PRN Comment: IV starts or blood draws.
Frequency: PRN 11/10/13 0225 - 11/10/13 2128
Released by: Viviano, Andrea K, RN 11/10/13 0225
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Procedure Orders

No orders found

Other Orders (11/10/13 - 11/10/13)

Discharge to Home Self Care [131064872]

Electronically signed by: **Fitch, Tyler W, MD on 11/10/13 1406** Status: **Discontinued**
Ordering user: Fitch, Tyler W, MD 11/10/13 1406 Ordering provider: Fitch, Tyler W, MD
Authorized by: Fitch, Tyler W, MD
Cosigning events:
Electronically cosigned by Vazquez-Melendez, Elsa V, MD 11/10/13 1426 for Ordering
Frequency: 1 Time 11/10/13 1415 - 1 Occurrences Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Discharge to Home Self Care [131064878]
Electronically signed by: **Fitch, Tyler W, MD on 11/10/13 1406** Status: **Discontinued**
Ordering user: Fitch, Tyler W, MD 11/10/13 1406 Ordering provider: Fitch, Tyler W, MD
Authorized by: Fitch, Tyler W, MD
Cosigning events:
Electronically cosigned by Vazquez-Melendez, Elsa V, MD 11/10/13 1426 for Ordering
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Discontinue Foley Catheter if present [131064873]

Electronically signed by: **Fitch, Tyler W, MD on 11/10/13 1406** Status: **Discontinued**
Ordering user: Fitch, Tyler W, MD 11/10/13 1406 Ordering provider: Fitch, Tyler W, MD
Authorized by: Fitch, Tyler W, MD
Frequency: 1 Time 11/10/13 1415 - 1 Occurrences Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Discontinue Foley Catheter if present [131064879]
Electronically signed by: **Fitch, Tyler W, MD on 11/10/13 1406** Status: **Discontinued**
Ordering user: Fitch, Tyler W, MD 11/10/13 1406 Ordering provider: Fitch, Tyler W, MD
Authorized by: Fitch, Tyler W, MD
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Call MD For: Severe Uncontrolled Pain [131064874]

Electronically signed by: **Fitch, Tyler W, MD on 11/10/13 1406** Status: **Active**
Ordering user: Fitch, Tyler W, MD 11/10/13 1406 Ordering provider: Fitch, Tyler W, MD
Authorized by: Fitch, Tyler W, MD
Frequency: 11/10/13 -
Diagnoses:
Suspected child sexual abuse [V71.6 (ICD-9-CM)]

Follow Up: With Doctor 1 [131064875]

Electronically signed by: **Fitch, Tyler W, MD on 11/10/13 1406** Status: **Active**
Ordering user: Fitch, Tyler W, MD 11/10/13 1406 Ordering provider: Fitch, Tyler W, MD
Authorized by: Fitch, Tyler W, MD
Frequency: 11/10/13 -
Diagnoses:
Suspected child sexual abuse [V71.6 (ICD-9-CM)]
Questions:
Doctor: Dr. Krieger
When: Routine health maintenance as scheduled
Patient/Parents to call for appointment? Yes
Please make appointment prior to discharge No

Discontinue IV if present [131064876]

Electronically signed by: **Fitch, Tyler W, MD on 11/10/13 1406** Status: **Discontinued**
Ordering user: Fitch, Tyler W, MD 11/10/13 1406 Ordering provider: Fitch, Tyler W, MD
Authorized by: Fitch, Tyler W, MD
Frequency: 1 Time 11/10/13 1415 - 1 Occurrences Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Discontinue IV if present [131064880]
Electronically signed by: **Fitch, Tyler W, MD on 11/10/13 1406** Status: **Discontinued**
Ordering user: Fitch, Tyler W, MD 11/10/13 1406 Ordering provider: Fitch, Tyler W, MD
Authorized by: Fitch, Tyler W, MD
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Call MD For: Temperature >101.4 [131064877]

Electronically signed by: **Fitch, Tyler W, MD on 11/10/13 1406** Status: **Active**
Ordering user: Fitch, Tyler W, MD 11/10/13 1406 Ordering provider: Fitch, Tyler W, MD
Authorized by: Fitch, Tyler W, MD
Frequency: 11/10/13 -
Diagnoses:
Suspected child sexual abuse [V71.6 (ICD-9-CM)]

Other Orders (11/10/13 - 11/10/13) (continued)

Call MD For: Temperature >101.4 [131064877] (continued)

IP Consult to Social Services [131064870]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0725** — Status: **Discontinued**
Mode: Ordering in Telephone with readback mode — Communicated by: Viviano, Andrea K, RN
Ordering user: Viviano, Andrea K, RN 11/10/13 0331 — Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Frequency: 1 Time 11/10/13 0330 - 1 Occurrences — Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]
Questions:
Reason for Consult? Financial

IP Consult to Social Services [131064871]
Electronically signed by: **Logan, Tori, DO on 11/10/13 0725** — Status: **Discontinued**
Mode: Ordering in Telephone with readback mode — Communicated by: Viviano, Andrea K, RN
Ordering user: Viviano, Andrea K, RN 11/10/13 0331 — Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]
Questions:
Reason for Consult? Financial

Full Code [131064853]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** — Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 — Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Frequency: Continuous 11/10/13 0230 - Until Specified — Released by: Viviano, Andrea K, RN 11/10/13 0225
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Full Code [131064864]
Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** — Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 — Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Measure Weight [131064854]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** — Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 — Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Frequency: UNIT ROUTINE 11/10/13 0225 - Until Specified — Released by: Viviano, Andrea K, RN 11/10/13 0225
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]
Comments:
Weigh per Unit Routine

Vital Signs per unit routine [131064856]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** — Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 — Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Frequency: UNIT ROUTINE 11/10/13 0225 - Until Specified — Released by: Viviano, Andrea K, RN 11/10/13 0225
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]
Questions:
May do Rectal Temperature Yes

Notify Physician: 6-12 Months [131064857]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** — Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 — Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Frequency: Continuous 11/10/13 0230 - Until Specified — Released by: Viviano, Andrea K, RN 11/10/13 0225
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]
Comments:
Notify Physician for TEMPERATURE greater than 101.4 (38.5), HEART RATE less than 80 or greater than 120, RESPIRATORY RATE less than 25 or greater than 40, SBP less than 80 or greater than 100, DBP less than 55 or greater than 65, UOP less than 1 ml/kg/hr, increasing oxygen demands, change in neurologic status, or new onset/worsening pain.

Notify Physician: 6-12 Months [131064865]
Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** — Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 — Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]
Comments:
Notify Physician for TEMPERATURE greater than 101.4 (38.5), HEART RATE less than 80 or greater than 120, RESPIRATORY RATE less than 25 or greater than

Other Orders (11/10/13 - 11/10/13) (continued)

40, SBP less than 80 or greater than 100, DBP less than 55 or greater than 65, UOP less than 1 ml/kg/hr, increasing oxygen demands, change in neurologic status, or new onset/worsening pain.

Activity as Tolerated [131064858]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Frequency: PRN 11/10/13 0225 - Until Specified Released by: Viviano, Andrea K, RN 11/10/13 0225
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Place in Crib [131064859]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Frequency: Until Specified 11/10/13 0230 - Until Specified Released by: Viviano, Andrea K, RN 11/10/13 0225
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Place in Crib [131064866]
Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

DIET INFANT FORMULA-NO TRAY NEEDED [131064860]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Frequency: Effective Now 11/10/13 0230 - Until Specified Released by: Viviano, Andrea K, RN 11/10/13 0225
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

DIET INFANT FORMULA-NO TRAY NEEDED [131064867]
Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]

Intake and Output [131064861]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Frequency: Q8H 11/10/13 0230 - Until Specified Released by: Viviano, Andrea K, RN 11/10/13 0225
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]
Comments:
Number of Voids and Stools

Intake and Output [131064868]
Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]
Comments:
Number of Voids and Stools

IP Consult to Pediatric Resource Center [131064862]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** Status: **Completed**
Ordering user: Logan, Tori, DO 11/10/13 0211 Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Frequency: 1 Time 11/10/13 0230 - 1 Occurrences Released by: Viviano, Andrea K, RN 11/10/13 0225
Questions:
Reason for Consult? maternal concern for sexual abuse
Comments:
This order will help facilitate communication and documentation. HOWEVER, PLEASE FOLLOW HOSPITAL CONSULT POLICY REGARDINING PROVIDER TO PROVIDER COMMUNICATION.

IP Consult to Pediatric Resource Center [131064869]
Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** Status: **Completed**
Ordering user: Logan, Tori, DO 11/10/13 0211 Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Questions:

Other Orders (11/10/13 - 11/10/13) (continued)

Reason for Consult? maternal concern for sexual abuse
Comments:
This order will help facilitate communication and documentation. HOWEVER, PLEASE FOLLOW HOSPITAL CONSULT POLICY REGARDINING PROVIDER TO PROVIDER COMMUNICATION.

Nursing Communication [131064863]

Electronically signed by: **Logan, Tori, DO on 11/10/13 0211** Status: **Discontinued**
Ordering user: Logan, Tori, DO 11/10/13 0211 Ordering provider: Logan, Tori, DO
Authorized by: Logan, Tori, DO
Frequency: Until D/C 11/10/13 0211 - Until Specified Discontinued by: Auto-Discontinue, System 11/10/13 2128 [Patient Discharge]
Comments:
Please offer jar baby food to patient.

ED-Outpatient with Observation Services [131064851]

Electronically signed by: **Montgomery, Daniel L, MD on 11/10/13 0122** Status: **Completed**
Ordering user: Montgomery, Daniel L, MD 11/10/13 0122 Ordering provider: Vazquez-Melendez, Elsa V, MD
Authorized by: Vazquez-Melendez, Elsa V, MD
Cosigning events:
Electronically cosigned by Vazquez-Melendez, Elsa V, MD 11/10/13 1426 for Ordering
Frequency: 1 Time 11/10/13 0130 - 1 Occurrences
Questions:
Admitting Physician VAZQUEZ-MELENDEZ, ELSA LUCIA
Admitting Diagnosis alleged abuse
Level of Care General Acute
Patient Care Floor/Unit general pediatrics
Patient Class Outpatient with Observation Services

ED-Outpatient with Observation Services [131064852]
Electronically signed by: **Montgomery, Daniel L, MD on 11/10/13 0122** Status: **Completed**
Ordering user: Montgomery, Daniel L, MD 11/10/13 0122 Ordering provider: Vazquez-Melendez, Elsa V, MD
Authorized by: Vazquez-Melendez, Elsa V, MD
Cosigning events:
Electronically cosigned by Vazquez-Melendez, Elsa V, MD 11/10/13 1426 for Ordering
Questions:
Admitting Physician VAZQUEZ-MELENDEZ, ELSA LUCIA
Admitting Diagnosis alleged abuse
Level of Care General Acute
Patient Care Floor/Unit general pediatrics
Patient Class Outpatient with Observation Services

Medications

Historical Medications Entered This Encounter

This print group is not available in inpatient encounters. Please contact a system administrator.

Multi-Disciplinary Problems (Active)

Care Plan

There are no active problems.

Care Plan Notes

Plan of Care by Viviano, Andrea K, RN at 11/10/2013 5:24 AM

Author: Viviano, Andrea K, RN | Service: (none) | Author Type: Registered Nurse
Filed: 11/10/2013 5:24 AM | Note Time: 11/10/2013 5:24 AM | Status: Signed
Editor: Viviano, Andrea K, RN (Registered Nurse)

Problem: General Plan of Care - Pediatrics
Goal: PLAN OF CARE REVIEWED
Plan of Care mutually reviewed/revised with the patient and/or other representative during this shift or as per policy.
Outcome: Ongoing (see interventions/notes)
Plan of Care reviewed with: mother

Patient Progress: No change

Outcome Summary: VSS and afebrile since arrival to unit. No pain indicated. Eating, drinking, and voiding. PRC to see pt today. Mom at bedside and updated on POC. Will continue to monitor.

All Meds and Administrations

lidocaine (LMX) 4 % cream CREA [131064855]

Status: Discontinued (Past End Date/Time), Reason: Patient Discharge

Ordering Provider: Logan, Tori, DO
Ordered On: 11/10/13 0225
Dose (Remaining/Total): - (-/-)
Route: Topical
Admin Instructions: Applied topically once 30-90 minutes prior to procedure.

Starts/Ends: 11/10/13 0225 - 11/10/13 2128
Frequency: PRN
Rate/Duration: - / -

(No admins scheduled or recorded for this medication)

Patient Lines/Drains/Airways Status

Active Medication Lines

None

Flowsheets (all recorded)

Peds Vitals Simple

	11/10/13 1706	11/10/13 1200	11/10/13 1153	11/10/13 0839	11/10/13 0800
Vital Signs					
Temp	98 °F (36.7 °C) -CT at 11/10/13 1912		97.6 °F (36.4 °C) -KS at 11/10/13 1153	97.2 °F (36.2 °C) -KS at 11/10/13 0840	
Temp src	Axillary -CT at 11/10/13 1912		Axillary -KS at 11/10/13 1153	Axillary -KS at 11/10/13 0840	
Pulse	138 -CT at 11/10/13 1912		116 -KS at 11/10/13 1153	127 -KS at 11/10/13 0840	
Resp	26 -CT at 11/10/13 1912		24 -KS at 11/10/13 1153	24 -KS at 11/10/13 0840	
BP				91/43 mmHg -KS at 11/10/13 0840	
Vitals Signs Positioning			Prone -KS at 11/10/13 1153	Sitting -KS at 11/10/13 0840	
Oxygen Therapy					
SpO2	100 % -CT at 11/10/13 1912		100 % -CT at 11/10/13 1912	98 % -KS at 11/10/13 0840	
O2 Device	None (Room air) -CT at 11/10/13 1912		None (Room air) -KS at 11/10/13 1153	None (Room air) -KS at 11/10/13 0840	
Pain/Comfort/Sleep Assessments					
R: Pain rFLACC Score: Rest		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0837
Sleep/Rest/Relaxation					no problem identified;awake -DL at 11/10/13 0931
Pain/Comfort Interventions					
Fever Reduction/Comfort Measures					lightweight bedding;lightweight clothing -DL at 11/10/13 0931
RETIRED PEWS (Pediatric Early Warning Score)					
RETIRED BEHAVIOR		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931
Cardiovascular		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931
Pulse		116 -DL at 11/10/13 1220			127 -DL at 11/10/13 0931
Respiratory		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931
Respirations		24 -DL at 11/10/13 1220			26 -DL at 11/10/13 0931
Nebulizers 1/4 Hourly		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931
Exception Algorithm Applies		No -DL at 11/10/13 1220			No -DL at 11/10/13 0931
PEWS Score		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931
PEWS (Pediatric Early Warning Score)					
Persistent Vomiting Following Surgery		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931

	11/10/13 0530	11/10/13 0300	11/10/13 0210	11/10/13 00:05:10	11/09/13 2250
Vital Signs					
Temp	-- temp. not obtainable, RN notified -SM at 11/10/13 0536		97.8 °F (36.6 °C) -MW at 11/10/13 0221	97.7 °F (36.5 °C) -ML at 11/10/13 0005	
Temp src	Axillary -SM at 11/10/13 0536		Axillary -MW at 11/10/13 0221	Axillary -ML at 11/10/13 0005	
Pulse	110 -SM at 11/10/13 0536		178 irritable -MW at 11/10/13 0221		118 -RR at 11/09/13 2251
Resp	24 -SM at 11/10/13 0536		27 -MW at 11/10/13 0221		24 -RR at 11/09/13 2251
BP			101/64 mmHg -MW at 11/10/13 0221		
Vitals Signs Positioning			Sitting -MW at 11/10/13 0221		Sitting -RR at 11/09/13 2251
Oxygen Therapy					
SpO2	98 % -SM at 11/10/13 0536		100 % -MW at 11/10/13 0221		99 % -RR at 11/09/13 2251

Flowsheets (all recorded) (continued)

Peds Vitals Simple (continued)

	11/10/13 0530	11/10/13 0300	11/10/13 0210	11/10/13 00:05:10	11/09/13 2250
O2 Device	None (Room air) -SM at 11/10/13 0536		None (Room air) -MW at 11/10/13 0221		None (Room air) -RR at 11/09/13 2251
Height and Weight					
Height			26.38" -MW at 11/10/13 0221		
Weight			18 lb 14.7 oz (8.58 kg) -MW at 11/10/13 0221		19 lb (8.618 kg) -RR at 11/09/13 2251
BSA (Calculated - sq m)			0.4 sq meters -MW at 11/10/13 0221		
BMI (Calculated)			19.2 -MW at 11/10/13 0221		
Head Cir			46.5 cm (18.31") -MW at 11/10/13 0221		
RETIRED Abdomen circumference			16.73" -MW at 11/10/13 0221		
Pain/Comfort/Sleep Assessments					
R: Pain rFLACC Score: Rest		0 -AV at 11/10/13 0305			
Comfort/Acceptable Pain Level		0 -AV at 11/10/13 0305			
Sleep/Rest/Relaxation		awake -AV at 11/10/13 0305			
Pain/Comfort Interventions					
Fever Reduction/Comfort Measures		lightweight bedding;lightweight clothing -AV at 11/10/13 0305			
RETIRED PEWS (Pediatric Early Warning Score)					
RETIRED BEHAVIOR		0 -AV at 11/10/13 0305			
Cardiovascular		0 -AV at 11/10/13 0305			
Pulse		178 -AV at 11/10/13 0317			
Respiratory		0 -AV at 11/10/13 0305			
Respirations		27 -AV at 11/10/13 0317			
Nebulizers 1/4 Hourly		0 -AV at 11/10/13 0305			
Exception Algorithm Applies		No -AV at 11/10/13 0305			
PEWS Score		0 -AV at 11/10/13 0305			
PEWS (Pediatric Early Warning Score)					
Persistent Vomiting Following Surgery		0 -AV at 11/10/13 0305			

Flowsheets (all recorded)

Peds I/O

	11/10/13 1800	11/10/13 1300	11/10/13 0915	11/10/13 0841	11/10/13 0215
Intake					
P.O.	180 mL -DL at 11/10/13 1926		180 mL -DL at 11/10/13 1220		
% Diet Eaten			50 % oatmeal -DL at 11/10/13 1220		
Output					
Urine		42 mL with stool -DL at 11/10/13 1433	88 mL -DL at 11/10/13 0915	180 mL -KS at 11/10/13 0841	
Unmeasurable Output					
Urine Occurrence	1 -DL at 11/10/13 1926				1 -AV at 11/10/13 0522
Stool Occurrence	1 -DL at 11/10/13 1926				

Flowsheets (all recorded)

Pediatric Patient Care Summary

	11/10/13 1200	11/10/13 1109	11/10/13 0800	11/10/13 0300	11/10/13 0210
Cognitive/Neuro/Behavioral Assessments					
Cognitive/Neuro/Behavioral WDL			WDL -DL at 11/10/13 0929	WDL -AV at 11/10/13 0305	
Head Circumference					
Head Cir					46.5 cm (18.31") -MW at 11/10/13 0221
Pain/Comfort Assessments					
R: Pain rFLACC Score: Rest	0 -DL at 11/10/13 1220		0 -DL at 11/10/13 0837	0 -AV at 11/10/13 0305	
Comfort/Acceptable Pain Level				0 -AV at 11/10/13 0305	
R: Face (rFLACC Pain Rating: Rest)	0-->no particular expression or smile -DL at 11/10/13 1220		0-->no particular expression or smile -DL at 11/10/13 0837	0-->no particular expression or smile -AV at 11/10/13 0305	
R: Legs (rFLACC Pain Rating: Rest)	0-->normal position or relaxed -DL at 11/10/13 1220		0-->normal position or relaxed -DL at 11/10/13 0837	0-->normal position or relaxed -AV at 11/10/13 0305	
R: Activity (rFLACC Pain Rating: Rest)	0-->lying quietly, normal position, moves easily -DL at 11/10/13 1220		0-->lying quietly, normal position, moves easily -DL at 11/10/13 0837	0-->lying quietly, normal position, moves easily -AV at 11/10/13 0305	
R: Cry (rFLACC Pain Rating: Rest)	0-->no cry (awake or asleep) -DL at 11/10/13 1220		0-->no cry (awake or asleep) -DL at 11/10/13 0837	0-->no cry (awake or asleep) -AV at 11/10/13 0305	
R: Consolability (rFLACC Pain Rating: Rest)	0-->content, relaxed -DL at 11/10/13 1220		0-->content, relaxed -DL at 11/10/13 0837	0-->content, relaxed -AV at 11/10/13 0305	
Pediatric Preferred Pain Scale (Non-Verbal)	rFLACC (Revised Face Legs Arms Cry Consolability Scale) -DL at 11/10/13 1220		rFLACC (Revised Face Legs Arms Cry Consolability Scale) -DL at 11/10/13 0837	rFLACC (Revised Face Legs Arms Cry Consolability Scale) -AV at 11/10/13 0305	
Pain/Comfort Interventions					
Fever Reduction/Comfort Measures			lightweight bedding;lightweight clothing -DL at 11/10/13 0931	lightweight bedding;lightweight clothing -AV at 11/10/13 0305	
Sleep/Rest/Relaxation Assessments					
Sleep/Rest/Relaxation			no problem identified;awake -DL at 11/10/13 0931	awake -AV at 11/10/13 0305	
Safety Assessments					
Safety WDL			WDL -DL at 11/10/13 0931	WDL -AV at 11/10/13 0305	
Pediatric Falls Risk, Humpty Dumpty Score:					
Age			4 -DL at 11/10/13 0931	4 -AV at 11/10/13 0305	
Gender			1 -DL at 11/10/13 0931	1 -AV at 11/10/13 0305	
Diagnosis			1 -DL at 11/10/13 0931	1 -AV at 11/10/13 0305	
Cognitive Impairments			1 -DL at 11/10/13 0931	1 -AV at 11/10/13 0305	
Environmental Factors			3 -DL at 11/10/13 0931	3 -AV at 11/10/13 0305	
Response to surgery/sedation/anesthesia			1 -DL at 11/10/13 0931	1 -AV at 11/10/13 0305	
Medication Usage			1 -DL at 11/10/13 0931	1 -AV at 11/10/13 0305	
Total			12 -DL at 11/10/13 0931	12 -AV at 11/10/13 0305	
Safety Interventions					
Safety Precautions/Fall Reduction			environmental modification;lighting adjusted for task/safety;low bed;fall reduction program maintained;family at bedside;security transponder on my child-4294	environmental modification;family at bedside;lighting adjusted for task/safety;security transponder on 4924 -AV at 11/10/13 0305	

Flowsheets (all recorded) (continued)

Pediatric Patient Care Summary (continued)

	11/10/13 1200	11/10/13 1109	11/10/13 0800	11/10/13 0300	11/10/13 0210
			-DL at 11/10/13 0931		
Infection Prevention			environmental surveillance;hydration promoted;nutrition promoted;promote handwashing;rest/sleep promoted -DL at 11/10/13 0931	environmental surveillance;hydration promoted;nutrition promoted;promote handwashing;rest/sleep promoted -AV at 11/10/13 0305	
All Alarms			none present -DL at 11/10/13 0931	none present -AV at 11/10/13 0305	
PEWS (Pediatric Early Warning Score)					
Persistent Vomiting Following Surgery	0 -DL at 11/10/13 1220		0 -DL at 11/10/13 0931	0 -AV at 11/10/13 0305	
RETIRED PEWS (Pediatric Early Warning Score)					
RETIRED BEHAVIOR	0 -DL at 11/10/13 1220		0 -DL at 11/10/13 0931	0 -AV at 11/10/13 0305	
Cardiovascular	0 -DL at 11/10/13 1220		0 -DL at 11/10/13 0931	0 -AV at 11/10/13 0305	
Pulse	116 -DL at 11/10/13 1220		127 -DL at 11/10/13 0931	178 -AV at 11/10/13 0317	
Respiratory	0 -DL at 11/10/13 1220		0 -DL at 11/10/13 0931	0 -AV at 11/10/13 0305	
Respirations	24 -DL at 11/10/13 1220		26 -DL at 11/10/13 0931	27 -AV at 11/10/13 0317	
Nebulizers 1/4 Hourly	0 -DL at 11/10/13 1220		0 -DL at 11/10/13 0931	0 -AV at 11/10/13 0305	
Exception Algorithm Applies	No -DL at 11/10/13 1220		No -DL at 11/10/13 0931	No -AV at 11/10/13 0305	
PEWS Score	0 -DL at 11/10/13 1220		0 -DL at 11/10/13 0931	0 -AV at 11/10/13 0305	
Cardiac Assessments					
Cardiac WDL			WDL -DL at 11/10/13 0931	WDL -AV at 11/10/13 0317	
Peripheral Neurovascular Assessments					
Peripheral Neurovascular WDL			WDL -DL at 11/10/13 0931	WDL -AV at 11/10/13 0317	
Respiratory Assessments					
Respiratory WDL			WDL -DL at 11/10/13 0931	WDL -AV at 11/10/13 0317	
Nutrition Assessments					
Diet/Feeding Assistance			assisted with feeding -DL at 11/10/13 0931	assisted with feeding -AV at 11/10/13 0317	
Diet/Nutrition Prescription			formula;age appropriate -DL at 11/10/13 0931	formula;age appropriate -AV at 11/10/13 0317	
Diet/Feeding Tolerance			good -DL at 11/10/13 0931	good -AV at 11/10/13 0317	
Fluids			adequate -DL at 11/10/13 0931	adequate -AV at 11/10/13 0317	
Gastrointestinal Assessments					
GI WDL			WDL -DL at 11/10/13 0931	WDL -AV at 11/10/13 0317	
Genitourinary Assessments					
GU WDL			WDL -DL at 11/10/13 0931	WDL -AV at 11/10/13 0317	
Musculoskeletal Assessments					
Musculoskeletal WDL			WDL -DL at 11/10/13 0931	WDL -AV at 11/10/13 0317	
Musculoskeletal Interventions					
Activity			up ad lib -DL at 11/10/13 0931	up ad lib -AV at 11/10/13 0317	
Skin Assessments					
Skin WDL			WDL -DL at 11/10/13 0931	WDL -AV at 11/10/13 0317	
Mobility (Braden Q)			4-->no limitations -DL at 11/10/13 0931	4-->no limitations -AV at 11/10/13 0317	
Activity (Braden Q)			4-->patient too young to ambulate or walks frequently -DL at 11/10/13 0931	3-->walks occasionally -AV at 11/10/13 0317	

Flowsheets (all recorded) (continued)

Pediatric Patient Care Summary (continued)

	11/10/13 1200	11/10/13 1109	11/10/13 0800	11/10/13 0300	11/10/13 0210
Sensory Perception (Braden Q)			4-->no impairment -DL at 11/10/13 0931	4-->no impairment -AV at 11/10/13 0317	
Moisture (Braden Q)			4-->rarely moist -DL at 11/10/13 0931	4-->rarely moist -AV at 11/10/13 0317	
Friction and Shear (Braden Q)			4-->no apparent problem -DL at 11/10/13 0931	4-->no apparent problem -AV at 11/10/13 0317	
Nutrition (Braden Q)			3-->adequate -DL at 11/10/13 0931	3-->adequate -AV at 11/10/13 0317	
Tissue Perfusion and Oxygenation (Braden Q)			4-->excellent -DL at 11/10/13 0931	4-->excellent -AV at 11/10/13 0317	
Braden Q Score (if 16 or less activate Pressure Ulcer, Risk guideline)			27 -DL at 11/10/13 0931	26 -AV at 11/10/13 0317	
Skin Interventions					
Hygiene Care		bath, complete;dress/undress;in continence care;linen change;perineal care;shampoo;tub bath;per care provider x1 -KS at 11/10/13 1109			
Coping/Psychosocial Response Assessments					
Observed Emotional State			calm -DL at 11/10/13 0931	calm -AV at 11/10/13 0317	
Mother Involvement in Care			at bedside;attentive to patient;interacting with patient;participating in care;supportive of patient -DL at 11/10/13 0931	at bedside;attentive to patient -AV at 11/10/13 0317	
Coping/Psychosocial Response Interventions					
Plan of Care Reviewed with			mother -DL at 11/10/13 0931	mother -AV at 11/10/13 0317	
Coping/Independence			anticipatory guidance provided;care explained to patient/family prior to performing;choices provided for parents/family;family involvement promoted;questions answered;safe, supportive environment facilitated;sleep/rest promoted;family support provided;goal setting facilitated;parental/family verbalization encouraged;reassurance provided -DL at 11/10/13 0931	anticipatory guidance provided;care explained to patient/family prior to performing;choices provided for parents/family;family involvement promoted;questions answered;safe, supportive environment facilitated;sleep/rest promoted -AV at 11/10/13 0317	
Pain/Comfort Assessments					
R: Presence of Pain	non-verbal indicator of pain/discomfort not present -DL at 11/10/13 1220		non-verbal indicator of pain/discomfort not present -DL at 11/10/13 0837	non-verbal indicator of pain/discomfort not present -AV at 11/10/13 0305	

	11/10/13 0201	11/10/13 0002
Glasgow Coma Scale(28d to 18mo)		
Eye Opening		4-->(E4) spontaneous -ML at 11/10/13 0002
Best Motor Response		6-->(M6) moves spontaneously and purposely -ML at 11/10/13 0002
Best Verbal Response		5-->(V5) coos and babbles -ML at 11/10/13 0002
Score (Glasgow Coma Scale)		15 -ML at 11/10/13 0002
Respiratory Assessments		
Rhythm/Pattern		no shortness of

Flowsheets (all recorded) (continued)

Pediatric Patient Care Summary (continued)

	11/10/13 0201	11/10/13 0002
(Respiratory)		breath;unlabored -ML at 11/10/13 0002
Nutrition Assessments		
Nutrition Risk Screen (Every 4 Days/Sig Change)	no indicators present -AV at 11/10/13 0209	

Flowsheets (all recorded)

Pediatric Patient Profile

	11/10/13 1035	11/10/13 0210	11/10/13 0201
General Information			
Preferred Language			English -AV at 11/10/13 0209
Patient Belongings			stroller;clothing -AV at 11/10/13 0201
Disposition of Belongings			Mom -AV at 11/10/13 0201
Advance Directives			
Medical Decision Maker Assessment			Has legal guardian to make decisions (Comment) -AV at 11/10/13 0209
Medical Decision Maker, if patient unable		Julia Eickmaier -AV at 11/10/13 0211	
Medical Decision Maker phone number		815-876-7479 -AV at 11/10/13 0211	
Living Will			-- addressed by registration -AV at 11/10/13 0209
Current Health			
Reason for Admission as Stated by Patient/Parent/Caregiver			signs of sexual malestation from past -AV at 11/10/13 0209
Services Anticipated at Discharge	none -RH at 11/10/13 1035		none -AV at 11/10/13 0209
Anticipated Discharge Disposition	home with assist -RH at 11/10/13 1035		home -AV at 11/10/13 0209
Health and Illness			
Previous General Health			excellent -AV at 11/10/13 0209
Healthy Maintenance Behaviors			-- immunizations not UTD-none -AV at 11/10/13 0209
Anticipated Discharge Needs			
Anticipated Changes Related to Illness	inability to care for self -RH at 11/10/13 1035		none -AV at 11/10/13 0209
Does the patient/caregiver have any financial concerns regarding discharge needs?	None -RH at 11/10/13 1035		
Perinatal History			
Gestational Age (wk)			40 weeks -AV at 11/10/13 0209
Birth Weightt (Lbs/Ounces)			8 lb (3.629 kg) -AV at 11/10/13 0209
Role Relationships			
Lives With			mother;grandfather -AV at 11/10/13 0209
Pets			cat -AV at 11/10/13 0209
Parent Marital Status			other (see comments) not together -AV at 11/10/13 0209
Court Ordered Visitation			no -AV at 11/10/13 0209
Abuse Screen, Profile (Pediatric)			
Do you feel safe going back to the place where you live?			Unable to assess due to age range or developmental state -AV at 11/10/13 0209
RN Abuse Observation			
Child has unexplained bruises, welts, burns, fractures, lacerations or abrasions			No -AV at 11/10/13 0209
Child appears frightened of			No -AV at 11/10/13 0209

Flowsheets (all recorded) (continued)

Pediatric Patient Profile (continued)

	11/10/13 1035	11/10/13 0210	11/10/13 0201
parents/caregivers?			
Mental Health Suicide Risk (RETIRED)			
Suicidal Ideation			other (see comments) N/A -AV at 11/10/13 0209
Nutrition Risk Screen			
Nutrition Risk Screen (Every 4 Days/Sig Change)			no indicators present -AV at 11/10/13 0209
Nutrition Review of Systems			
Diet/Nutrition Prior to Admission			baby food;finger foods;formula [1] Enfamil Gentleease ad lib -AV at 11/10/13 0215
GI/GU Review of Systems (GI/GU)			
Gastrointestinal Conditions			denies -AV at 11/10/13 0209
Values/Beliefs/Spiritual Care			
(F) Faith: What cultural, spiritual, religious practices, folk remedies/values are important for us to know?			N/A -AV at 11/10/13 0209
Referrals			
Referrals			child life;social work/services -AV at 11/10/13 0209

Flowsheets (all recorded)

ED CPM Reporting

	11/10/13 1706	11/10/13 1200	11/10/13 1153	11/10/13 0839	11/10/13 0800
Pre-Hospital Treatment					
O2 Device	None (Room air) -CT at 11/10/13 1912		None (Room air) -KS at 11/10/13 1153	None (Room air) -KS at 11/10/13 0840	
Pain Assessments					
Pediatric Preferred Pain Scale (Non-Verbal)		rFLACC (Revised Face Legs Arms Cry Consolability Scale) -DL at 11/10/13 1220			rFLACC (Revised Face Legs Arms Cry Consolability Scale) -DL at 11/10/13 0837
R: Face (rFLACC Pain Rating: Rest)		0-->no particular expression or smile -DL at 11/10/13 1220			0-->no particular expression or smile -DL at 11/10/13 0837
R: Legs (rFLACC Pain Rating: Rest)		0-->normal position or relaxed -DL at 11/10/13 1220			0-->normal position or relaxed -DL at 11/10/13 0837
R: Activity (rFLACC Pain Rating: Rest)		0-->lying quietly, normal position, moves easily -DL at 11/10/13 1220			0-->lying quietly, normal position, moves easily -DL at 11/10/13 0837
R: Cry (rFLACC Pain Rating: Rest)		0-->no cry (awake or asleep) -DL at 11/10/13 1220			0-->no cry (awake or asleep) -DL at 11/10/13 0837
R: Consolability (rFLACC Pain Rating: Rest)		0-->content, relaxed -DL at 11/10/13 1220			0-->content, relaxed -DL at 11/10/13 0837
R: Pain rFLACC Score: Rest		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0837
Vitals					
Temp src	Axillary -CT at 11/10/13 1912		Axillary -KS at 11/10/13 1153	Axillary -KS at 11/10/13 0840	
Vitals Signs Positioning			Prone -KS at 11/10/13 1153	Sitting -KS at 11/10/13 0840	
SpO2	100 % -CT at 11/10/13 1912		100 % -CT at 11/10/13 1912	98 % -KS at 11/10/13 0840	
E - Vitals (15 min before transfer)					
Temp	98 °F (36.7 °C) -CT at 11/10/13 1912		97.6 °F (36.4 °C) -KS at 11/10/13 1153	97.2 °F (36.2 °C) -KS at 11/10/13 0840	
Pulse	138 -CT at 11/10/13 1912		116 -KS at 11/10/13 1153	127 -KS at 11/10/13 0840	
Resp	26 -CT at 11/10/13 1912		24 -KS at 11/10/13 1153	24 -KS at 11/10/13 0840	
BP				91/43 mmHg -KS at 11/10/13 0840	
Pediatric Falls Risk, Humpty Dumpty Score:					
Age					4 -DL at 11/10/13 0931
Gender					1 -DL at 11/10/13 0931
Diagnosis					1 -DL at 11/10/13 0931
Cognitive Impairments					1 -DL at 11/10/13 0931
Environmental Factors					3 -DL at 11/10/13 0931
Response to surgery/sedation/anesthesia					1 -DL at 11/10/13 0931
Medication Usage					1 -DL at 11/10/13 0931
Total					12 -DL at 11/10/13 0931
RETIRED PEWS (Pediatric Early Warning Score)					
RETIRED BEHAVIOR		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931
Cardiovascular		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931
Pulse		116 -DL at 11/10/13 1220			127 -DL at 11/10/13 0931
Respiratory		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931
Respirations		24			26

Flowsheets (all recorded) (continued)

ED CPM Reporting (continued)

	11/10/13 1706	11/10/13 1200	11/10/13 1153	11/10/13 0839	11/10/13 0800
		-DL at 11/10/13 1220			-DL at 11/10/13 0931
Nebulizers 1/4 Hourly		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931
Exception Algorithm Applies		No -DL at 11/10/13 1220			No -DL at 11/10/13 0931
PEWS Score		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931
PEWS (Pediatric Early Warning Score)					
Persistent Vomiting Following Surgery		0 -DL at 11/10/13 1220			0 -DL at 11/10/13 0931

	11/10/13 0530	11/10/13 0300	11/10/13 0210	11/10/13 00:05:10	11/10/13 0002
Pre-Hospital Treatment					
O2 Device	None (Room air) -SM at 11/10/13 0536		None (Room air) -MW at 11/10/13 0221		
Triage Plan (SFMC)					
ED Destination					Pod 2 -ML at 11/10/13 0002
Pain Assessments					
Comfort/Acceptable Pain Level		0 -AV at 11/10/13 0305			
Pediatric Preferred Pain Scale (Non-Verbal)		rFLACC (Revised Face Legs Arms Cry Consolability Scale) -AV at 11/10/13 0305			
R: Face (rFLACC Pain Rating: Rest)		0-->no particular expression or smile -AV at 11/10/13 0305			
R: Legs (rFLACC Pain Rating: Rest)		0-->normal position or relaxed -AV at 11/10/13 0305			
R: Activity (rFLACC Pain Rating: Rest)		0-->lying quietly, normal position, moves easily -AV at 11/10/13 0305			
R: Cry (rFLACC Pain Rating: Rest)		0-->no cry (awake or asleep) -AV at 11/10/13 0305			
R: Consolability (rFLACC Pain Rating: Rest)		0-->content, relaxed -AV at 11/10/13 0305			
R: Pain rFLACC Score: Rest		0 -AV at 11/10/13 0305			
Infant Assessment					Yes -ML at 11/10/13 0002
Presence Of Pain					appears comfortable -ML at 11/10/13 0002
Vitals					
Temp src	Axillary -SM at 11/10/13 0536		Axillary -MW at 11/10/13 0221	Axillary -ML at 11/10/13 0005	
Vitals Signs Positioning			Sitting -MW at 11/10/13 0221		
SpO2	98 % -SM at 11/10/13 0536		100 % -MW at 11/10/13 0221		
Respiratory Assessment					
Rhythm/Pattern (Respiratory)					no shortness of breath;unlabored -ML at 11/10/13 0002
E - Vitals (15 min before transfer)					
Temp	-- temp. not obtainable, RN notified -SM at 11/10/13 0536		97.8 °F (36.6 °C) -MW at 11/10/13 0221	97.7 °F (36.5 °C) -ML at 11/10/13 0005	
Pulse	110 -SM at 11/10/13 0536		178 irritable -MW at 11/10/13 0221		
Resp	24 -SM at 11/10/13 0536		27 -MW at 11/10/13 0221		
BP			101/64 mmHg -MW at 11/10/13 0221		
Pediatric Falls Risk, Humpty Dumpty Score:					
Age		4			

Flowsheets (all recorded) (continued)

ED CPM Reporting (continued)

	11/10/13 0530	11/10/13 0300	11/10/13 0210	11/10/13 00:05:10	11/10/13 0002
		-AV at 11/10/13 0305			
Gender		1 -AV at 11/10/13 0305			
Diagnosis		1 -AV at 11/10/13 0305			
Cognitive Impairments		1 -AV at 11/10/13 0305			
Environmental Factors		3 -AV at 11/10/13 0305			
Response to surgery/sedation/anesthesia		1 -AV at 11/10/13 0305			
Medication Usage		1 -AV at 11/10/13 0305			
Total		12 -AV at 11/10/13 0305			
Height and Weight					
Height			26.38" -MW at 11/10/13 0221		
Weight			18 lb 14.7 oz (8.58 kg) -MW at 11/10/13 0221		
BSA (Calculated - sq m)			0.4 sq meters -MW at 11/10/13 0221		
BMI (Calculated)			19.2 -MW at 11/10/13 0221		
RETIRED Abdomen circumference			16.73" -MW at 11/10/13 0221		
Glasgow Coma Scale(28d to 18mo)					
Eye Opening					4-->(E4) spontaneous -ML at 11/10/13 0002
Best Motor Response					6-->(M6) moves spontaneously and purposely -ML at 11/10/13 0002
Best Verbal Response					5-->(V5) coos and babbles -ML at 11/10/13 0002
Score (Glasgow Coma Scale)					15 -ML at 11/10/13 0002
RETIRED PEWS (Pediatric Early Warning Score)					
RETIRED BEHAVIOR		0 -AV at 11/10/13 0305			
Cardiovascular		0 -AV at 11/10/13 0305			
Pulse		178 -AV at 11/10/13 0317			
Respiratory		0 -AV at 11/10/13 0305			
Respirations		27 -AV at 11/10/13 0317			
Nebulizers 1/4 Hourly		0 -AV at 11/10/13 0305			
Exception Algorithm Applies		No -AV at 11/10/13 0305			
PEWS Score		0 -AV at 11/10/13 0305			
PEWS (Pediatric Early Warning Score)					
Persistent Vomiting Following Surgery		0 -AV at 11/10/13 0305			

	11/10/13 0001	11/09/13 2251	11/09/13 2250
Triage Plan			
ESI Level		2 -RR at 11/09/13 2251	
Distress Level			
Distress Level	None -ML at 11/10/13 0001		
Pre-Hospital Treatment			
O2 Device			None (Room air) -RR at 11/09/13 2251

Flowsheets (all recorded) (continued)

ED CPM Reporting (continued)

	11/10/13 0001	11/09/13 2251	11/09/13 2250
OSF ED SYMP ONSET			
Date Symptoms Started		11/09/13 -RR at 11/09/13 2251	
Vitals			
Vitals Signs Positioning			Sitting -RR at 11/09/13 2251
SpO2			99 % -RR at 11/09/13 2251
E - Vitals (15 min before transfer)			
Pulse			118 -RR at 11/09/13 2251
Resp			24 -RR at 11/09/13 2251
Height and Weight			
Weight			19 lb (8.618 kg) -RR at 11/09/13 2251
Weight Method			Actual -RR at 11/09/13 2251

Flowsheets (all recorded)

Bed status

	11/10/13 0135	11/10/13 0125
Bed status		
Bed status	Clean and Ready 626-01 -ST at 11/10/13 0135	Requested PEDS -ST at 11/10/13 0125

Flowsheets (all recorded)

Pastoral Care

	11/10/13 1316
Pastoral Care Visits	
Pastoral Visited With	Visit with patient -TH at 11/10/13 1316
Visited By	Pastoral Care Team -TH at 11/10/13 1316
Reason for Visit	Patient/family request -TH at 11/10/13 1316
Religious Background	
Faith Preference	Christian -TH at 11/10/13 1316
Pastoral Spiritual Assessment	
Support Systems	Parent(s) -TH at 11/10/13 1316
Length of Visit	30 - 45 minutes -TH at 11/10/13 1316
Pastoral Care Interventions	
Visit Interventions	Family support;Listening;Health discussion;Assist with verbalization of feelings;Prayer -TH at 11/10/13 1316
RETIRED - Emotional Status	Concerned;Fearful;Appreciation;Value in prayer;Trusting -TH at 11/10/13 1316

Flowsheets (all recorded)

Patient Belongings

	11/10/13 0201
General Information	
Patient Belongings	stroller;clothing -AV at 11/10/13 0201
Disposition of Belongings	Mom -AV at 11/10/13 0201

Flowsheets (all recorded)

Care Transitions

	11/10/13 1800	11/10/13 1036	11/10/13 1035	11/10/13 0212	11/10/13 0211
Poor Health Literacy					
Is patient able to state reason for admission?					Yes -AV at 11/10/13 0211
Patient Support					
Does patient lack support?					No -AV at 11/10/13 0211
Depression Screen					
Patient not screened due to:					Under age 18 -AV at 11/10/13 0211
Prior Hospitalization					
Non-elective, ED, INPT or OBS in last 6 months at any facility?					No -AV at 11/10/13 0211
Principal Diagnosis					
Is principal diagnosis a high risk diagnosis?					No -AV at 11/10/13 0212
Palliative Care					
Does this patient have a chronic illness that might get worse over time?				No -AV at 11/10/13 0212	
Does the patient have chronic uncontrolled pain?				No -AV at 11/10/13 0212	
Problem Medications					
Education needs of PTA/current meds				No -AV at 11/10/13 0212	
Financial needs of PTA/current meds				No -AV at 11/10/13 0212	
Patient Safety needs of PTA/current meds				No -AV at 11/10/13 0212	
Pharmacy Med Adherence					
How often do you miss taking your medication?				Never -AV at 11/10/13 0212	
How often are you unable to obtain medications?				Never -AV at 11/10/13 0212	
Home Health					
Home Health Needed		No -RH at 11/10/13 1036			
Choices Provided?		No -RH at 11/10/13 1036			
Anticipated Discharge Needs					
Anticipated Changes Related to Illness			inability to care for self -RH at 11/10/13 1035		
Services Anticipated at Discharge			none -RH at 11/10/13 1035		
Durable Medical Equipment needs:			-- n/a -RH at 11/10/13 1035		
Durable Medical Equipment Company Name			n/a -RH at 11/10/13 1035		
Durable Medical Equipment Company Phone Number			n/a -RH at 11/10/13 1035		
Durable Medical Equipment Company Fax Number			n/a -RH at 11/10/13 1035		
Anticipated Discharge Disposition			home with assist -RH at 11/10/13 1035		
Does the patient/caregiver have any financial concerns regarding discharge needs?			None -RH at 11/10/13 1035		
Discharge Planning					
Living Arrangements			Parent -RH at 11/10/13 1036		

Flowsheets (all recorded) (continued)

Care Transitions (continued)

	11/10/13 1800	11/10/13 1036	11/10/13 1035	11/10/13 0212	11/10/13 0211
Support Systems			Parent -RH at 11/10/13 1036		
Assistance Needed			n/a -RH at 11/10/13 1036		
Type of Residence			Private residence -RH at 11/10/13 1036		
Care Facility Name			n/a -RH at 11/10/13 1036		
Home Care/Hospice/Palliative Care Services			No -RH at 11/10/13 1036		
Type of Home Care/Hospice Services			None -RH at 11/10/13 1036		
Patient expects to be discharged to:			home with supervision -RH at 11/10/13 1036		
The list of facilities/home health/DME options was provided to the patient/caregiver?			No -RH at 11/10/13 1036		
Mode of transportation at discharge:			Family car -RH at 11/10/13 1036		
Consults/Referrals					
Community Resources		None -RH at 11/10/13 1036			
Consults/Referrals		Medical Social Worker;Child Protective Services -RH at 11/10/13 1036			
Handoff					
Handoff Communication		Not Applicable -RH at 11/10/13 1036			
Nurse Review					
Readmission Risk Assessment Reviewed	Reviewed no change -DL at 11/10/13 1825	Reviewed with changes -RH at 11/10/13 1036		Reviewed no change -AV at 11/10/13 0212	

	11/10/13 0210	11/10/13 0201
Presentation of Patient		
Is the patient complex?	No -AV at 11/10/13 0211	
Medical Decision Maker Assessment		Has legal guardian to make decisions (Comment) -AV at 11/10/13 0209
Medical Decision Maker, if patient unable	Julia Eickmaier -AV at 11/10/13 0211	
Medical Decision Maker phone number	815-876-7479 -AV at 11/10/13 0211	
Anticipated Discharge Needs		
Anticipated Changes Related to Illness		none -AV at 11/10/13 0209
Services Anticipated at Discharge		none -AV at 11/10/13 0209
Anticipated Discharge Disposition		home -AV at 11/10/13 0209
OTHER		
Medical Decision Maker	Patient/Legal Guardian -AV at 11/10/13 0211	

Flowsheets (all recorded)

MRSA Admission Screening Assessment

	11/10/13 0209
MRSA Screening Criteria	
Patient is being admitted to an intensive care unit	No -AV at 11/10/13 0210
Patient is a resident of Nursing Home or Assisted Living Facility, Prison or Jail, Shelter or is homeless	No -AV at 11/10/13 0210
Patient lives with a person with MRSA (family or other)	No -AV at 11/10/13 0210
Patient has a history of MRSA infection or colonization	No -AV at 11/10/13 0210
Patient receives hemodialysis	No -AV at 11/10/13 0210
Patient has an existing line, peg, trach, tube, catheter	No -AV at 11/10/13 0210
Patient has open wounds/skin abrasions (excludes new traumatic wounds), or purulent drainage from a percutaneous device (PEG, Tracheostomy, Drain, Line)	No -AV at 11/10/13 0210
Patient has been hospitalized within the last 3 months	No -AV at 11/10/13 0210
Patient has had IV/PO antibiotics in the last 3 months	No -AV at 11/10/13 0210
Patient has a history of IV drug abuse	No -AV at 11/10/13 0210
Patient is HIV positive	No -AV at 11/10/13 0210

Flowsheets (all recorded)

Influenza Vaccine

	11/10/13 0210
Influenza Contraindications	
Previously immunized this flu season (September 1 through March 31)	No -AV at 11/10/13 0210
History of Guillan-Barre syndrome within 6 weeks after the previous influenza vaccine	No -AV at 11/10/13 0210
Bone marrow transplant within the past 6 months	No -AV at 11/10/13 0210

Audit Information

Ref #	Row Name	Time Taken	Time Recorded	Value	User
1	Diet/Nutrition Prior to Admission	11/10/13 0201	11/10/13 0215	baby food;finger foods;formula Enfamil Gentleease ad lib	AV
			11/10/13 0214	(p) baby food;finger foods;formula	AV

User Key

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

Initials	Name	Effective Dates
AV	Viviano, Andrea K, RN	07/10/12 - 02/10/15
DL	Lindberg, Danielle N, RN	01/23/13 - 04/19/16
CT	Tucker, Caitlin E, SFNC	08/12/13 - 03/10/14
KS	Southerland, Kathrine E	07/10/12 - 07/23/15
MW	Weber, Meghan J, STUDENT	09/05/13 - 04/12/16
ML	Leyden, Melinda M, RN	07/10/12 - 02/25/14
RH	Haedicke, Rita A, RN	07/10/12 - 04/08/15
RR	Roy, Robert J, RN	07/10/12 - 12/22/15
ST	Turner, Sherry J	07/10/12 - 04/08/15
SM	Maurer, Stephanie N	07/10/12 - 02/12/15
TH	Heinz, Teresa E	07/10/12 - 04/19/16

Patient Education

Education

Title: Generic Teaching Goals/Outcomes (Resolved)

Points For This Title

Point: Discharge (Resolved)
Description: When to call your doctor, how to take new medications and side effects, when to follow-up with doctor.

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Key Learner	Acceptance	TB	VU		DL 11/10/13 1845	Done

Point: Room/Unit Orientation (Resolved)
Description: Generic Teaching

Learning Progress Summary

Learner	Readiness	Method	Response	Comment	Documented by	Status
Key Learner	Acceptance	TB	VU		AV 11/10/13 0224	Done

Point: Pain and Pain Management (Resolved)
Description: Pain and Pain Management
Summary: Learning progress - not on file.

Point: Medications (Resolved)
Description: Medications
Summary: Learning progress - not on file.

Point: Diagnostic Tests/Procedures (Resolved)
Description: Diagnostic Tests/Procedures

Patient Education (continued)

Education (continued)

Summary: Learning progress - not on file.

Point: Dietary Modifications (Resolved)
Description: Dietary Modifications
Summary: Learning progress - not on file.

Point: Hygiene/Infection Prevention (Resolved)
Description: Hygiene/Infection Prevention
Summary: Learning progress - not on file.

Point: Rehabilitation (Resolved)
Description: Rehabilitation
Summary: Learning progress - not on file.

Point: Medical Equipment/Supplies (Resolved)
Description: Medical Equipment/Supplies
Summary: Learning progress - not on file.

Point: Tobacco Cessation (Resolved)
Description: Tobacco Cessation
Summary: Learning progress - not on file.

Point: Resources for Support (Resolved)
Description: Resources for Support
Summary: Learning progress - not on file.

Title: Pain, Acute (Pediatric) (Resolved)

Points For This Title

Point: Effective Pain Control Options/Strategies (Resolved)
Description: Effective Pain Control Options/Strategies (e.g., types/dose of medications that work for the patient, positioning, relaxation, activity modification measures, assistive devices to minimize pain with mobility, nonpharmacologic measures for infants, environmental modifications)
Summary: Learning progress - not on file.

Point: Lifestyle Alterations, Present and Future (Resolved)
Description: Lifestyle Alterations, Present and Future (e.g., BADLs/IADLs, sleep/rest, mobility, physical activity, stress level, play/activities, school, peer interaction)
Summary: Learning progress - not on file.

Point: Current Level of Pain and Comparison To Desired Level Using Age/Developmentally Appropriate Scale (Resolved)
Description: Current Level of Pain and Comparison To Desired Level Using Age/Developmentally Appropriate Scale
Summary: Learning progress - not on file.

Point: Family/Caregiver/Significant Other Participation In Pain Management Plan (Resolved)
Description: Family/Caregiver/Significant Other Participation In Pain Management Plan
Summary: Learning progress - not on file.

Point: Personal Risk Factors And Signs/Symptoms Related To Acute Pain (Resolved)
Summary: Learning progress - not on file.

Point: Factors That Aggravate or Relieve Pain (Resolved)
Description: Factors That Aggravate or Relieve Pain (e.g., stimulus, activity, positioning)
Summary: Learning progress - not on file.

Point: Self-Advocacy Techniques (Resolved)
Description: Self-Advocacy Techniques (e.g., communicate need for pain medication, pain management plan)
Summary: Learning progress - not on file.

Title: Fall/Trauma/Injury Risk (Pediatric) (Resolved)

Points For This Title

Point: Personal Risk Factors and Signs/Symptoms Related To Injury Risk (Resolved)
Description: Personal Risk Factors and Signs/Symptoms Related To Injury Risk
Summary: Learning progress - not on file.

Point: Risk Factor Reduction, Behavior Modification To Prevent Injury (Resolved)
Description: Risk Factor Reduction, Behavior Modification To Prevent Injury
Summary: Learning progress - not on file.

Patient Education (continued)

Education (continued)

Point: Safe Performance of BADL/ IADL (Resolved)
Description: Safe Performance of BADL/ IADL
Summary: Learning progress - not on file.

Point: Identify Potential Environmental Hazards and Risk Reduction Strategies (Resolved)
Description: Identify Potential Environmental Hazards and Risk Reduction Strategies
Summary: Learning progress - not on file.

Point: Lifestyle Alterations, Present and Future (Resolved)
Description: Lifestyle Alterations, Present and Future (e.g., use of assistive devices, energy conservation techniques, wait to perform activities that involve risk until assistance is available, environmental modification to decrease potential hazards)
Summary: Learning progress - not on file.

User Key

Initials	Effective Dates	Name	Provider Type	Discipline
AV	07/10/12 - 02/10/15	Viviano, Andrea K, RN	Registered Nurse	Nurse
DL	01/23/13 - 04/19/16	Lindberg, Danielle N, RN	Registered Nurse	Nurse

Discharge Instructions Kramer, Madeline H (MR # 05477474)

Date	Status	User	User Type	Discharge Note
11/10/13 1401	Reviewed	Fitch, Tyler W, MD	Resident	Original
Note:				

Follow-up with pediatrician as previously scheduled for regular health maintenance visits.

I certify that I have reviewed the discharge orders and information on this patient.
TYLER W FITCH, MD; 11/10/2013, 2:01 PM

Encounter-Level Documents - 11/09/2013:

Electronic signature on 11/10/2013 12:14 AM

Encounter-Level E-Signatures:

Hospital - OSF ESig ARA IL ENG - Received on 11/10/2013

Patient: Kramer, Madeline

MRN No. 05477474

OSF HEALTHCARE SYSTEM
AUTHORIZATION/RELEASE/AGREEMENT TO PAY

1. **Authorization for Medical Treatment**. I authorize my physician(s) and his/her designee(s), other individuals with privileges to provide services at OSF Hospitals ("Hospital") and OSF Medical Group physician and provider practices ("OSFMG") (collectively "OSF") and their employees to provide medical, surgical and hospital services to me, including diagnostic tests and therapeutic procedures necessary for the diagnosis and treatment of my illness or condition. I further authorize medical care, testing, and treatment as necessary in emergency situations to preserve my life and health and to protect the health of persons involved in my care without first obtaining consent from me or my family.

I understand that, with the exception of some physicians whose names may be provided to me upon request, all physicians furnishing Hospital services to me are independent physicians who are not employees or agents of Hospital, and that the Hospital is not responsible for their opinions, decisions or medical procedures performed. Independent physicians include, but are not limited to, consultants and specialists (e.g., surgeons, anesthesiologists, internists, pathologists, and radiologists). I understand that Hospital may be a teaching institution, providing clinical training opportunities for medical, nursing and allied health students and residents. I consent to such students and residents being involved in my care and treatment and understand that they are not employees of my physician or the Hospital.

2. Release of Information for Billing. I authorize release to insurance companies or their administering entities, governmental agencies or their intermediaries, third party payers providing benefits to me, and to third-party collectors, copies of all medical records or other information necessary to determine available benefits and to obtain payment for the services rendered to me during my current admission or course of treatment. I understand that: (a) my medical records may contain information relating to mental health, developmental disabilities, alcohol and/or drug abuse diagnosis and/or treatment, HIV/Aids test results and genetic information, and I authorize release of such medical records for purposes of billing and collection; (b) I have the right to inspect and to obtain a copy of the information disclosed; (c) this authorization is valid until the date one year following today's date; (d) I have the right to revoke this authorization at any time, except to the extent that actions were taken in reliance thereon; and (e) if I refuse to sign or revoke this authorization, OSF may not be able to release medical information which is necessary to process claims for insurance benefits and I will be billed directly for these services.

3. Assignment of Benefits. I assign to OSF all claims and rights to payment under any insurance policy or health plan of which Patient is a beneficiary, and consent to whatever legal action OSF and its agents determine appropriate to obtain payment. The undersigned authorize the application of any overpayment to any unpaid bill at OSF for Patient for which the undersigned is responsible that has not been paid in full at the time of the overpayment. If a credit balance of $10.00 or less results on any non-Medicare or Medicaid patient account after all payment has been posted, that balance will be applied to any other outstanding account, including appropriate family members, who have an outstanding balance. If there is no individual or family account to apply the credit balance the amount will only be refunded if the patient or their representative requests the amount to be returned.

4. Agreement to Pay. I acknowledge that the OSF Charity Assistance Policy which includes the Hospital Uninsured Patient Discount Act is available for review upon request. I understand that I have 60 days from the date of discharge or treatment to apply for OSF Charity Assistance. I agree to pay the rates set forth in the Hospital's Charge Master for all services, facilities and supplies provided to me and my dependents not paid by insurance within 60 days from the date of first billing, subject to my application and eligibility for charity assistance or other payment arrangements approved in writing by OSF. The Charge Master is hereby incorporated and made a part of this Agreement. I was given the opportunity to review the Charge Master and either reviewed the Charge Master or expressly declined to do so.

The foregoing provisions do not apply if OSF has agreed to accept payment for services provided to Patient from a payer such as the Medicare and Medicaid programs, from a health maintenance organization (HMO) or a preferred provider organization (PPO), and instead I will pay the amounts that are the responsibility of the Patient under those programs or agreements. Certain physicians and allied health professionals such as consultants, radiologists, pathologists, anesthesiologists, etc, may provide services that are billed separately from OSF. If your heath plan does not cover all the charges, your financial responsibility may include payment for the uncovered portion of those charges. Questions regarding insurance coverage or benefit levels should be directed to the Patient's health care plan and the Patient's certificate of coverage. I agree to pay all costs incurred in the collection of my payment obligation to OSF including collection agency fees, attorney's fees and costs of suit.

5. Personal Valuables. I agree that OSF is not liable for loss, theft, damage or destruction of any personal property on the premises including money, jewelry, glasses, dentures, hearing aids, and documents, unless placed in a safe maintained by OSF for the safekeeping of personal property.

NOTICE TO UNDERSIGNED

Do not sign this Agreement before you read it. This Agreement is effective as of the date of my signature and applies to all services provided during the Patient's current admission or course of treatment. If the undersigned is not the Patient, the undersigned represent and warrant that they have full legal authority to sign this Agreement on behalf of the Patient. I have read and fully understand this Agreement. I acknowledge receipt of a copy of this Agreement.

Patient Name: Kramer, Madeline

MRN: 05477474
Date & Time: 11/10/2013 12:14:02 AM

Patient Signature:

Signature of OSF Witness:

Kramer, Madeline (MR # 05477474)

Discharge Summary — Madeline Kramer

Facility

Name	Address	Phone
SAINT FRANCIS MEDICAL CENTER	530 NE GLEN OAK AVE Peoria IL 61603-3117	309-655-2000

Attending Provider Information

Provider	pager	Service	Admission Date
Vazquez-Melendez V, Elsa, MD		Pediatrics	11/09/13

Actual LOS

1 day

Allergies as of 11/10/2013

No Known Allergies

Immunizations as of 11/10/2013 — Never Reviewed

No immunizations on file.

Please take these papers with you to your next doctor's appointment

Your To Do List

Future Orders	To Be Completed On or After	Please Complete By
Call MD For: Severe Uncontrolled Pain		
Follow Up: With Doctor 1		
Questions:	Responses:	
Doctor:	Dr. Krieger	
When:	Routine health maintenance as scheduled	
Patient/Parents to call for appointment?	Yes	
Please make appointment prior to discharge	No	
Call MD For: Temperature >101.4		

Discharge Instructions

Follow-up with pediatrician as previously scheduled for regular health maintenance visits.

I certify that I have reviewed the discharge orders and information on this patient.
TYLER W FITCH, MD; 11/10/2013, 2:01 PM

Discharge Medications

Disclaimer

The details from your pharmacy may be different from what is below. Ask your pharmacist or your doctor if you have any questions.

Current Discharge Medication List

Notice

You have not been prescribed any medications.

I understand:

Regular activity that I can handle is good for me.
I need to eat healthy foods and follow any special diets ordered by my doctor.
I need to keep ALL follow up appointments with my doctor, APN, or physician assistant.

For patients with Heart Failure:

I need to weigh myself daily and call the doctor if I gain 3 pounds in a day and/or 5 pounds in a week, unless my doctor told me something different.
If I have problems breathing I am to call my doctor or go to the nearest emergency room.

For patients that had a stroke:

I can try to stop a stroke or heart attack by controlling these risk factors:

- High Blood Pressure
- High Blood Cholesterol
- Diabetes
- Smoking
- Excessive Alcohol use
- Illicit Drugs or drugs NOT ordered by my doctor

Written information has been given to the patient or caregiver.

Daily Medication List

Notice

You have not been prescribed any medications.

AVS Printed This Encounter

Date/Time	Report	Action	User
11/10/2013 6:45 PM	After Visit Summary	Printed	Lindberg, Danielle N, RN

END OF REPORT